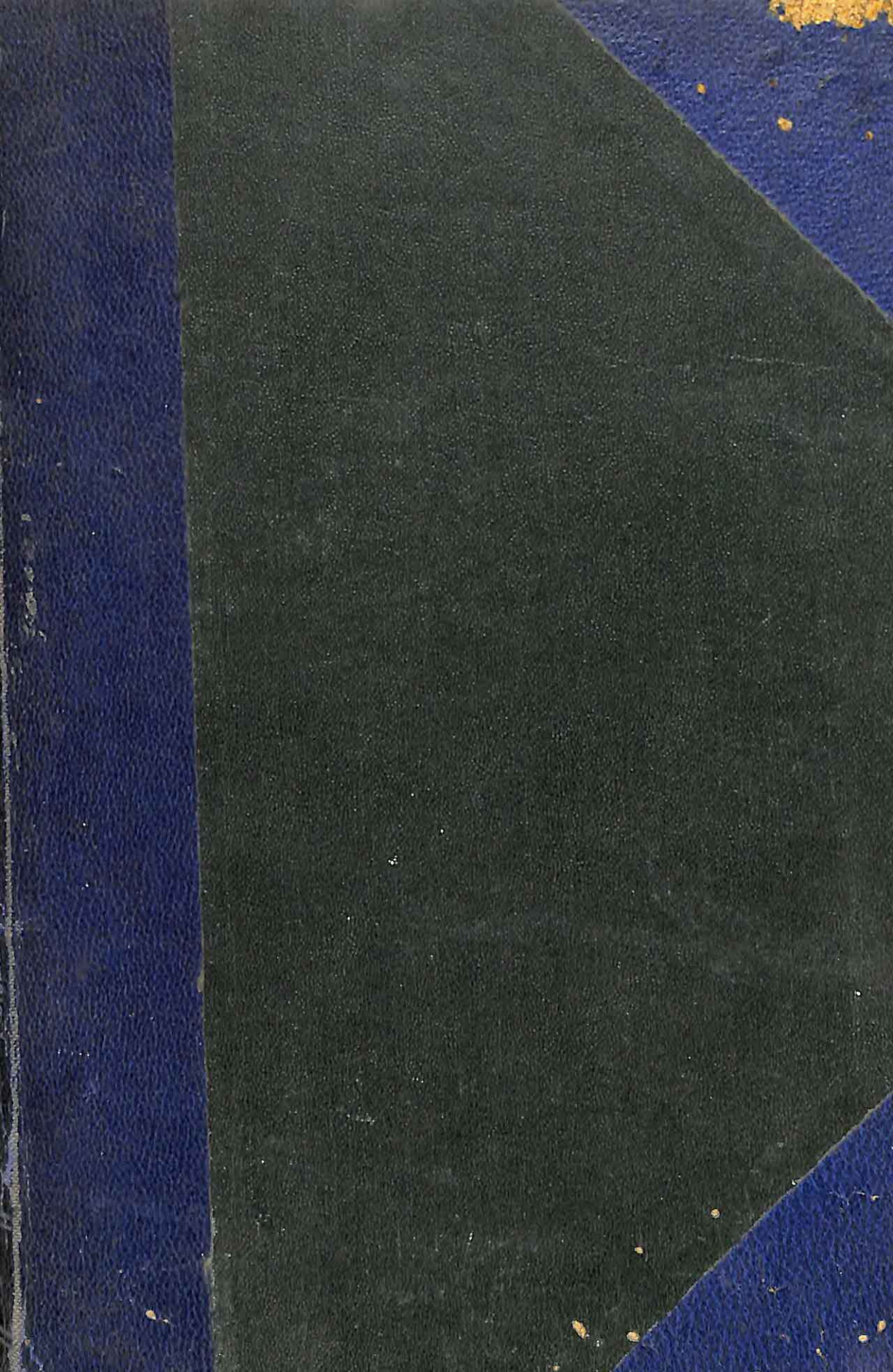




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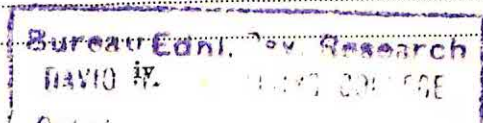


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American Journal of Psychotherapy

VOLUME 11

JULY, 1948

NUMBER 3

EDITORIAL

We wish to draw the attention of our readers to an interesting symposium which will be held in Washington, D. C. from September 11 to 15. The topic of this symposium is "Cooperation and Conflict among Living Organisms." The sponsoring organizations, to which our Association belongs, are the *Botanical Society of America*, the *Ecological Society of America*, the *Institute of Ethnic Affairs*, the *Institute of General Semantics*, the *Sociometric Institute*, the *Society for Applied Anthropology*, the *National Indian Institute*, and others.¹ The goal of the concerted effort of these organizations is expressed in the motto of the symposium: "Organizing Scientific Research for Peace."¹

During the second World War the Office of the Scientific Research and Development mobilized the leading representatives of our physical and biological sciences and fit them into a well-knit team with the objective of hastening the victory of our fighting teams. The success of this scientific cooperation generated the impulse to do with regard to social sciences what the great team of scientists during the War did with regard to physical, technical and biological sciences. THE ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOTHERAPY, in joining the other sponsoring societies, has not only endorsed their common aim, but also evidenced its conviction that psychiatry in general and psychotherapy in special have their well-defined objectives within the framework of such an effort.

Cooperation! Should it be possible to elevate this idea to a guiding philosophy of psychotherapy?

The idea of cooperation has always developed in the

¹ Information: Edward F. Haskell, 438 W. 116 St., New York 27, N. Y.

midst of, and parallel with, competitive and aggressive trends. We believe that this concept placed above that of competition (the latter taken from the ideology of sports) can greatly improve our interpersonal and international relationships. The phrase "Let the best man win", the ideas of "winning and losing", "victory and defeat", represent samples taken from the vocabulary of aggression. To "beat" an "opponent", to corner him and disarm him, is good—in games and sports. These concepts can, however, be kept out of the philosophy of our social life, and be replaced by the concept of cooperation.

We believe that rivalry—based as it is upon primordial edipal and sibling rivalry—undermines the relations of people. It creates in the individual as well as in the group latent feelings of guilt, which are based on the endopsychic conviction that our relations with our fellow-man are essentially insincere, and that what we really want more than anything else is the downfall of our "competitors." At the same time we also know that our fellow-man, reared in the same spirit as ourselves, nurtures the same sentiments toward us. The result is mutual distrust. Dog eats dog. Every man a Judas.

Can this festering undercurrent of aggression be stopped? We think that it is high time for us to utilize the knowledge imparted to us by deep psychology and to set up a new standard of values for our living and an inspiring objective for our psychotherapeutic endeavors. It is time that the psychiatrist, who is trained in guiding and molding human minds, place the competitive formula where it belongs, namely, within the individual himself; that he teach the individual to compare his (measurable) *factual performance*, not with that of others but with his own (measurable) *maximal capacity to perform*. That he offer him as a goal worth striving and struggling for, not the outfencing of his fellow man but the attaining of his own maximal functioning capacity; and that he show him ways to raising the peg of his maximal performance capacity steadily and dili-

gently. This policy should in the end contribute decidedly toward the psychological assanation of interpersonal relations. For it is capable of eliminating the individual's floating feelings of guilt and distrust toward his fellow-man together with feelings of envy, greed and aggression. Games and contests, sports and competitions, on national and international scale, would always remain the great siphoners of individual and mass aggression.

It is needless to emphasize that the psychiatrist is vitally concerned with all processes leading to the elimination of hate and aggression. He knows how often an obscure neurotic fear proves to be the individual's fear of his own antisocial reactions, how often undischarged anxiety turns, by projection, into aggression. As a matter of fact, most problems of psychopathology revolve around anxiety, guilt and hate. The psychiatrist must, therefore, prepare the individual for his part in the job of cooperation. He must demonstrate to him not only how "bad" he is "unconsciously", but also how "good" he is, and how "rich", and what dormant potentialities toward creative co-action with his fellow-man he possesses. The experiment of the United Nations may serve as encouragement in this respect. Scientists must help in the task of turning competitors into partners and, on a large scale, help to replace the present international free-for-all by a setup in which rights and duties are wisely distributed, among equal partners, united in a worldwide, democratic adventure of Organizing for Peace.

REMARKS ON SOME BASIC PROBLEMS OF DYNAMIC PSYCHOPATHOLOGY*

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The fundamental difference between psychoanalysis and the older methods of psychotherapy is that psychoanalysis for the first time tried to *uncover* the causes of neuroses; by way of contrast, the methods of treatment used previously, such as suggestion, e.g., might be called *covering* methods.

In order to find out what psychoanalysis wants to uncover we will do better by asking what it does *not* uncover and does not want to uncover. An example will demonstrate that: A mother loses her son in the war and is sad. We do not need psychoanalysis to understand the mother's feelings. The reason for this is that the psychological connection between loss of the son and sadness of the mother is entirely comprehensible. But it is not the principle of causation that makes the connection evident and comprehensible. If this were the case, repeated experience would increase the evidence. Seeing ten mothers who have lost their sons and are sad does not make me more certain that a mother is sad when she loses her son, neither will the repeated experience make me know more certainly the reason for the mother's sadness. Such evidence is not found by inductive methods and cannot be proven by experience.

It is psychologically comprehensible that a starving man will look for food or that a loving wife who does not get attention from her husband is unhappy. Although I may never have seen a starving man or a wife who is neglected by her husband it is comprehensible and evident to me that the man will look for food and that the wife is unhappy.

We call such mental connections comprehensible connections.¹

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¹ We must distinguish between two different kinds of comprehending or understanding. When the contents of thoughts clearly follow each other according to the rules of logic, i.e., when we apperceive a connection by *thought* exclusively, then we understand rationally. This is not strictly a psychological understanding but a comprehension of rational contents which a person possesses. If, however, we understand contents of thought or actions from the moods, fears, desires or the character of another person we then speak of the

Comprehensible connections are evident in themselves. They bear their power of conviction in themselves, and they are not proven by repeated experience. They are means by which the individual real occurrence is measured and recognized as more or less comprehensible. The comprehensible connections are not found by inductive methods; only their frequency is proved this way but not the connections themselves. One case, in reality, may give the occasion for comprehending such a connection, but its frequency does not add anything to its evidence.

In contrast to comprehensible connections, causal connections are gained by inductive methods. They lead to rules, laws, theories and sometimes they can be expressed in mathematical equations. Comprehensible connections can never lead to rules, laws and equations. Comprehensible connections are meaningful or, as we can just as well say, they are purposive. It is comprehensible, meaningful, purposive that I defend myself when I am attacked; that I become distrustful when I am deceived. It is the concept of the purposive context which is the basis of comprehensible connections. And it is logically impossible to base laws on it.²

Simple comprehensible connections are well-known to everybody. We may discover comprehensible connections ourselves or they can be shown to us by great minds (Shakespeare, Kierkegaard, Nietzsche, etc.). The more such connections we recognize in the individual case the greater the understanding of the individual.

All dynamic psychology is based on comprehensible connections. The question whether it is possible to base a science on such evidence, or, whether dynamic psychology is a science at all shall not be discussed here.³

For psychological connections which are comprehensible we do not need psychoanalysis. Psychoanalysis and dynamic psychopathology start where a psychological connection is *not* comprehensible but can be made comprehensible through the utilization of a material of which we are unaware.⁴ Dynamic psychopathology and

truly psychological understanding. The expression comprehensible connection is used here only for this kind of understanding.

² This problem is discussed in detail in my book, *Principles of General Psychopathology*, Philosophical Library, New York, 1949 (in preparation).

³ This problem is discussed in my aforementioned book.

⁴ We use here the term "unaware" instead of "unconscious" in order to avoid misunderstandings. "Unconscious" can have several different mean-

psychoanalysis end where the psychological connection ceases being comprehensible through utilization of the unaware. The object of this science, therefore, are the neuroses where such conditions are encountered. Not within the realm of *dynamic* psychopathology are the psychoses. They can never be made completely comprehensible. Here lies the limit of our psychological understanding, and here the causal explanation begins.

The purpose of dynamic psychopathology is to make psychological connections comprehensible through the unaware. Psychoanalytic approach in the individual case has the same goal. The action of a compulsive neurotic, e.g., one who has to retain everything he has touched unless it is something he had destroyed, and who in this way fills a whole room with junk, is not comprehensible. After we have found that he has the wish to kill his mother—a wish of which he is not aware—and that by keeping the junk, or destroying it, he controls all clues which could lead to the discovery of his criminal wish, his actions become comprehensible. All psychoanalytic treatment is based on the discovery of the unaware.

Since Freud it has been known that we “repress”⁵ that part of our mental activity that is unacceptable to the ego; we are, therefore, not aware of it. Again Freud’s theory has the merit which cannot be overestimated that it proves these conflicts frequently to be caused by the sexual drive. A man, for instance, who has sexual wishes toward his mother can certainly not allow himself to become aware of them. There are innumerable cases where the sex drive can be in conflict with the conscience or, as Freud calls it, with the “superego.” Neurosis is the result of this conflict. Freud has shown that the actions of such neurotics become comprehensible if we discover the material of which the patient is unaware. Through Freud this psychological connection is evident to us, we acknowledge it, and equipped with it, use it in the treatment of the individual case.



Besides the sex drive, there is another drive in any human being and in every animal, a drive which is much stronger than the sexual

ings, “unaware” being one of them.—The term “unconscious” is used as an adjective as well as the noun “the unconscious.” The term “unaware” is likewise used as an adjective and as the noun “the unaware.”

⁵ For more detailed discussion of the term “repression” see my aforementioned book.

drive. This is the *drive for self-preservation*. It should not be surprising that this drive is also a frequent cause of neuroses. It is true that in our civilization we are basically protected against danger to our lives. As neuroses, however, are very often caused by experiences in childhood, matters look entirely different. The child is helpless, and if the mother does not take care of the child, it may die. Only the mature animal or human is ready for life. And the human is mature only after about eighteen years. Considering that man is born more helpless than any animal, that it takes a quarter of his lifetime until he becomes mature, i.e., until he does not need any help and can feel complete confidence in himself, we see immediately that there are many possibilities that the drive of self-preservation can become the cause of deep conflicts.

The child enters this world in a helpless condition. There is an instinctive craving for protection in the child. When the mother or, later, the father also, protects the child, the child feels safe. In order to feel safe the child must attribute omnipotence to his parents. If the child feels that the parents are not there, he feels lost and that means that he becomes *aware* of his helplessness. Feeling helpless means being afraid of a danger to his life. Although with increasing age, particularly during adolescence, the child becomes more and more aware of his own strength and gains more and more confidence in himself, complete confidence in himself is reached only when the human being is fully equipped with everything which he needs to meet the dangers of life. This occurs when the human being is mature.

A child that has never become aware of his helplessness will feel safe as an adult. Such an adult feels confident in himself in every respect, independent of his actual abilities.

Whenever the child becomes aware of his helplessness, he experiences anxiety. Anxiety in the real sense of this term is fear of danger to his life or, differently expressed, fear of death.⁶ It shall not be denied, however, that anxiety can be caused by other dynamics such as those Freud has shown.

The contingencies whereby a child can become *aware* of his helplessness are innumerable. When, for instance, a human being loses his father or mother or both before reaching maturity; when the child feels that other siblings are favored; when the child is fright-

⁶ More detailed discussion about the term "anxiety" in my aforementioned book.

ened by the parents instead of having the feeling of being protected by them; or when the child is attacked by others and does not feel that the parents protect him: the child becomes aware of his helplessness. The means the child employs to get help or even to survive are manifold. The child may be stubborn, hostile, he may lie or he may render himself insensible to the loss of protection. As a consequence of the last, the child may become shy, may feel inadequate, or the like.

If the instinctive drive for protection was not satisfied in childhood, the individual may carry over feelings of inadequacy, inefficiency, or inferiority to his adult life. Although the person may be equipped physically and intellectually for life, he may not be aware of his own strength. In order to overcome this feeling of inferiority he may be in urgent need of recognition by others, which may give him a temporary relaxation. He may become hungry for power or for money, only to overcome his feeling of helplessness and to feel safe. Safety means that his life is safe. Other people, afraid that somebody might hurt them, may feel as helpless as they did in childhood, may retreat and live in seclusion. The consequence of the feeling of insecurity and helplessness may manifest itself in anti-social behavior of any kind: in a general hostility, in criminality or in a political fanaticism. The unsatisfied powerful drive for self-preservation which stands behind all these actions and strivings makes the behavior of these people comprehensible.

On the basis of this concept it becomes comprehensible why neurotics are so often found tense. Whenever our life is in danger we are tense. It is his feeling of helplessness which gives the neurotic the feeling of being in constant danger. Constant tension causes physical symptoms and diseases which have been described by many authors and which today are included in the vast realm of psychosomatic medicine.

It shall not be denied that tension and anxiety may also be caused through other conflicts. After careful examination of many neurotics it has become my opinion that in the majority of the cases the causes of the neuroses do not lie in the conflict with the sexual drive but in the conflict with the drive for self-preservation which has not been satisfied in childhood.

Even in transference as encountered during psychoanalytic treatment, the protection the patient receives is more significant as a healing factor than the sexual attachment to the analyst.

This concept combines the opinions of Freud and Adler. Freud showed the dynamics of repression, especially as applied to the sex drive, but he did not show the importance of the drive for self-preservation.⁷ Adler called our attention to the feeling of inferiority and its consequences but he failed to make comprehensible from where the inferiority feelings stem. He, therefore, had to formulate a theory about the somatic origin of the feeling of inferiority which cannot be proven; nor does it uncover a comprehensible connection.

I do not believe that all neuroses can be made understandable through the utilization of the unaware, of which we become aware through a conflict with the sex drive or the drive of self-preservation. Life is too manifold to be made comprehensible only on the basis of these two factors. However, what I attempted to show is that the frustrated drive for self-preservation, which is certainly stronger than the sexual drive, must be considered as one of the main factors in the development of neuroses.

⁷ On the basis mainly of theoretical considerations and not by showing the comprehensible connections, Freud comes to the conclusion that the drive of self-preservation is of libidinous or narcissistic character ("Beyond the Pleasure Principle"). In his effort to prove the supremacy of the sex drive Freud overlooked the comprehensible connection between the child's helplessness and his craving for protection, a connection which is entirely evident. Freud shows this tendency already in his "Introductory Lectures on Psychoanalysis." Here he tries to explain the anxiety of a child who is left alone, by the concept of dammed up libido and he does not acknowledge it to be fear based on reality.

CHARACTER TYPES

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This article is an attempt at a re-examination of our accepted terminology and concepts of character types in the light of current clinical experience.

On the re-examination of these one is surprised to note that, while the terms introvert and extravert, coined by Jung (1), nearly correspond to the terms cyclothymic and schizothymic, coined by Kretschmer (2), the former have been adopted almost universally, while the latter are mentioned now and then only; that while efforts are being made to raise psychology to the status of a science, the terms preferred are the ones which are, not only metaphysical, but altogether too ill-defined and too nebulous.

On the application of either of the above concepts one finds them to be, not only inadequate, but frequently misleading. Take, for instance, Jung's classifications. From his descriptions one gathers that the following features go with introversion: undue interest in one's own personality; lack of rapport with other people; lack of interest in what is going on in the environment; tendency to be shut-in, to hide one's own affairs from others; tendency to depreciate others; tendency to inactivity; interest in the remote and the abstract. With extraversion go the opposite features: lively interest in what is going on in the environment; rapport with other people; tendency to confide; tendency to be outspoken; tendency to appreciate others; tendency to mobility; interest in the concrete.

The writer's objections to Jung's classification are the following:

(A) The metaphysical concept of "version" is inadequate and misleading. It leads its author into difficulties from which he can—and often cannot—extricate himself only by means of many pages of arguments which are highly unconvincing. He is, for example, forced to conclude that one kind of people (introverted sensation type) experience their sensations subjectively and another kind of people (extraverted sensation type) experience their sensations objectively. This amounts to the statement that one kind of people touching ice, experience the coldness of the ice; the other kind of people touching ice, experience the coldness of their cold sensations. Another example is Jung's description of the extra-

verted feeling type. Here he is forced to conclude that there are two types of feeling: subjective feeling and feeling which is based on volition to feel in a certain way about a subject—a “feeling-judgment.” His type example is the woman who *volitionally* loves her man because he “corresponds in standing, age, capacity and family respectability with every reasonable requirement.” One cannot be persuaded that such a “feeling” is a feeling. Furthermore, the logical conclusion of the above is that the love of the woman who really loves her husband is an introverted feeling. If extraversion means a flow of libido towards something in the outer world, is not the latter a case of more positive and more dynamic outward flow?

(B) Apply Jung’s formula to people you know, and you are led to conclusions as extravagant as the above. Suppose it is night; and there are two people looking through a window. One is a well-groomed shop keeper. The other is an astronomer, a kindly man who, because of his preoccupation with his profession, is not as meticulous about his personal appearance nor as observant of his immediate surroundings. The former is watching the traffic below; the latter is fascinated by the light of Sirius, a star many billions of miles away. The latter, because of his oblivion to his surroundings and lack of rapport with those near him is, according to Jung’s formula, an introvert; the former—an extravert. Now in what direction does the libido flow in either of these men? The logical conclusion of Jung’s definitions is that libido which flows towards an object twenty or thirty yards away is flowing outward and the libido which flows towards an object billions of miles away is flowing inward.

(C) In the application of Jung’s formula to neurotics one meets with similar difficulties, the reason being the fact that the group of features that go with this type or with that type do not go together as do dark hair and brown eyes with a dark complexion. To which type does the neurasthenic belong? He is manifestedly over-interested in his own personality, in the physical as well as in the psychical aspect thereof. That he is asthenic goes without saying. But he is usually irritable, which implies increased response to the environment. He is in rapport with those around him. Often one finds him more than ordinarily outspoken—eager to reveal the outmost corner of his soul.

The hysteric offers a still greater problem. Hysteria is char-

acterized by over-suggestibility which implies, as Jung says, "exaggerated rapport with members of the family and a frankly imitatory accommodation to surrounding conditions," in other words, exaggerated extraversion. But the hysteric shows as exaggerated an interest in his own self, body and soul. Furthermore, being a case of psychic splitting, he belongs to what Kretschmer calls the schizoid group, the one closely allied to the (supposedly introverted) schizophrenics. Jung argues it out in his characteristic way. He considers hysteria as "a compensatory reaction from the side of the unconscious which manifests its opposition to the extravagant extraversion in the form of psychical disorders whereupon introversion of psychic energy becomes unavoidable." Let us imagine a case of hysteria and apply to it the above explanation. Here is a hysterical woman living with her sister who is paralyzed. One day she too becomes (hysterically) "paralyzed"—paralyzed because of her "exaggerated rapport" with her sister; a paralysis which is an "Imitatory accommodation." Her manifest tendency was to become paralyzed *because of extraversion*. But her unconscious came to the rescue and caused her to become paralyzed *because of introversion!*

(D) Jung's formulas fail as remarkably when they are used in the interpretation of those extreme conditions upon whose features they are based—dementia precox and manic-depressive psychosis. Here is a patient who is at present a typical manic. But only two months ago he was entirely uncommunicative and immobile; entirely absorbed in his imaginary ailments and misfortunes. In other words: he was in the depressive phase. Judging from his past, he will have alternations of depression and elation for the rest of his life. Where does he belong?

Apply Jung's formula to the schizophrenics as a group, and you will find it as ill fitting. Over one-third of the schizophrenics show manicky features. And to a great percentage of the rest the term introversion, in the sense of increased interest of one's own person, is inapplicable. The mental content of such schizophrenics consists usually of detective plots, of religious dramas, of plans against the bolsheviks, of absurd small-town talk, jobs, girls, etc., in other words, of "cabbages and kings." Self-consideration is prominent in those who are more or less depressed. The myth that schizophrenia is almost synonymous with self-contemplation springs from the fact that depression of a greater or lesser extent is present in the early

stages of this psychosis in the majority of cases, and that it is in these stages that their cases are being studied. Again, there is the great percentage of the dull and the partly mute who, because of their oblivion to their surroundings, are interpreted as thinking mainly of themselves, while their actual mental content consists chiefly of "cabbages and kings." Jung aptly describes the mentation of the schizophrenic as being practically the same as that of a person asleep and dreaming; and may one say that the content of his dreams is—in comparison with that of his waking state—characterized by self-considerations?

Introversion-extraversion corresponds, not to the polarity of schizophrenic-manic, but to the polarity of depression-elation. The schizophrenic-manic polarity corresponds more to that of interest-in-the-extra-environmental versus interest-in-the-intra-environmental. Jasper (3), testing normals, reported that "a significant relationship has been shown between a predominance of introverted interests . . . and the predominance of depression in characteristic affective tone and attitude."

(E) Jung's formula is relativistic. "Give the introvert a thorough congenial milieu," and he will become, for the time being, an extravert. Accordingly, introversion and extraversion are not features for themselves but depend upon the environment. But finding that in some environments some people are introverts and other people are extraverts and in other environments they are the reverse, the inference is that "version" is not the yardstick, that the innate differences between the types depend upon something else yet to be defined.

(F) There are introverts and there are extraverts; but the vast majority of people, as Jung himself states (4) are ambiverted. And does it make much difference to the observer whether the person in question is forty-five per cent introvert and fifty-five per cent extravert, or the reverse? In other words, the concept of "version" is applicable to too small a percentage to be of value. In the vast majority of people, not version, but something else is the distinguishing feature characterizing the person in question.

*

Kretschmer's classifications, also revolving around the schizophrenic-manic axis, are more realistic and the characters which he describes—cyclothymics and schizothymics—are more alive and more convincing; but—

(A) While the term schizophrenia applied to dementia precox patients is convincing, the term schizothymia applied to normals is entirely impossible and misleading. We clearly perceive cleavage in the person who can hold two convictions which are mutually exclusive. In the normal *all the data* are considered at the same time and a corresponding conviction is arrived at; in the precox such integration of all the data into one whole is apparently impossible: hence, one part of the data forms one entity and another part another entity which may be incongruous with it. We perceive similar cleavage in the incongruity of the affective content with that of the ideational. We may conceive this cleavage to be due to disturbances of inter-neuronic conductivity. But as applied to the paranoid precox, the term schizophrenia is entirely out of place. Here is an individual more than ordinarily integrated: all his ideational elements are interlinked and constellated about his central delusion. Yet even to this type the term schizophrenia is applicable since even in this form of dementia precox there is an *eventual* dilapidation not differing from that of hebephrenia. But when we come to consider the normals, we find that the term schizothymic, applied to the person who is usually more integrated than the cyclothymic, glaringly unfit and misleading.

Equally as contradictory to what it purports to describe is the term cyclothymia, based on the symptomatology of the circular form of manic-depressive psychosis wherein there are alternations of depression and elation. When we observe normals we find the majority of cyclothymics to be even-tempered and the majority of schizothymics to be temperamental—given to frequent changes of mood. In other words, the schizothymics are vastly more cycloid than the cyclothymics.

(B) The inadequacies and contradictions mentioned spring from the fact that the classification (of normals) is based upon the symptomatology of the morbid. Observations show that normal feature-groups are not analogous to (pathological) symptom-groups. In the morbid condition, especially when fully developed, several entities more frequently go together, as swelling, discoloration, pain and tenderness with infection. Not so in the normal. Whatever you decide to identify as personality traits, you find them to be as different in their grouping as the cars of the various makes at a ball game.

The normal person who shows such (normal) traits as are mimicked by the schizophrenic, usually shows with these—what is

the very antithesis of schizophrenia—a more solid integration. While one usually finds hostile attitudes among the schizophrenics, one has the impression that there are as many genuinely friendly and as many genuinely unfriendly ones among the slender as among the stout people. Schizophrenia is marked by antitheses: noisiness and mutism; resistiveness and catalepsy; stupor and excitement; freakish turns of thoughts and stereotypy, etc., etc. But one practically finds in schizophrenia no symptom which is the full antithesis of the marked hostility towards others—no *exaggerated* friendship, no extreme love for anyone. In dealing with normals one finds that “*Extremism*” in any field is more frequent among the schizothymics than among the cyclothymics, and that this extremism is as apt to be in the case of love as in the case of hatred. Observe that Jung places (by inference) the woman with a capacity for extreme love among the introverts. The lack of correspondence between normals and abnormals is seen in other directions also. Mobility, for instance, is greater among the manics than among the schizophrenics. But in the case of normals, the more slender people are usually more motile than some of the stout ones.

Kretschmer subdivides the schizoids into the hyperesthetic and the hypoesthetic; the cycloids he subdivides into the more or less elated and the more or less depressed. A study of the several cyclothymic subgroups which Kretschmer describes reveals—what he does not mention—that the cyclothymics too are divisible with respect to sensitiveness. A psychologist might have seen the situation from another angle; might have divided people into hyperesthetics and hypoesthetics and subdivided them into cyclothymics and schizothymics; but for Kretschmer, being a psychiatrist and, therefore, daily confronted by the problem of differential diagnosis between manic-depressive psychosis and dementia precox, it was natural to see things from his particular angle. Looking at normals through psychiatric glasses inevitably involves corresponding distribution of emphases resulting in portraitures wherein special resemblances are accentuated. Dealing with a group of units, units differing from each other, the decision as to which are the regular ones and which the exceptions depends upon the angle of approach. One must consider the fact that the brain, being a system of functions, when undergoing pathological changes, cannot but show these changes in terms of those functions. Descriptions of normals with reference to morbid manifestations is like interpreting the move-

ments of a limb as mimics of those movements brought about by the application of an electrode to the motor area of the brain.

(C) Here also we point out the fact that while there are cyclothymics and schizothymics, the majority of the people are neither the one nor the other, as would be expected as the result of inter-marriages, etc.

Given a vast number of individuals each with his repertoire of psychic features, we naturally expect marked differences as well as marked resemblances with respect to any given feature or feature-group. Now a feature has more than one aspect. Take, for instance, such a feature as cheerfulness. We may consider its visible facial manifestations; we may consider the muscular tonicities which go with such a state; we may consider the neuron processes whereof cheerfulness is a manifestation. Since all the above are aspects of the same entity, does it make any difference what particular aspect of that entity one considers for the purpose of classification, the one demonstrable by means of laboratory technic only or the one perceived and unmistakably identified even by the layman? That there are such features readily identified and differentiated is certain. The writer aims to show the adequacy of a classification based upon such features.

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No one will dispute the statement that some people are more dynamic than others. Special tests, if devised, would be useful to ascertain the degree of dynamia. But to demand special tests to prove that there are differences in dynamia were as reasonable as to demand special tests to prove that the sun rises in the East and sets in the West. Equally as indisputable is the statement that some people, either because of hereditary factors or because of training, are dynamic only in one field or in a restricted number of fields, and others are dynamic in a great number of fields. In other words: One dynamic individual has a special capacity for one or two kinds of activities only; another dynamic individual is a typical "Jack of all trades." It is obvious that a special capacity for a certain kind of activity is apt to consist of a group of capacities. For instance: the capacity for piano playing may consist of a special capacity for finger technique, a special capacity for differentiation of shades of tones, a special capacity for emotional appreciation of the music, etc., etc. For convenience' sake we will use the term capacity to mean any psychological element or group of elements

conceivable. Whether a marked capacity depends upon the anatomy or physiology of a definite brain locality, or upon other factors, as the chemistry of the body as a whole, we will consider such a capacity as dependent upon a mechanism exceptionally dynamic; and we will consider the instance of a person whose capacities are uneven (who has good capacities for some sort of activities or emotions and not for others) as a case of uneven distribution of dynamia, and the instance of the person whose capacities are even as a case of uniform distribution of dynamia. The former we will call HETERO-PHRENIC and the latter we will call HOMOPHRENIC. And since people differ not only in the uniformity of distribution of dynamia but also in the degree of dynamia, we will subdivide these types into hyperdynamic and hypodynamic individuals, the former describing the person of extreme activity or sensitivity, the latter—of extreme inactivity or insensitivity. The complete classification will be as follows:

NORMAL INDIVIDUALS

Homophrenic

Hyperdynamic, Mesodynamic, Hypodynamic

Mesophrenic

Hyperdynamic, Mesodynamic, Hypodynamic

Heterophrenic

Hyperdynamic, Mesodynamic, Hypodynamic

PSYCHOPATHIC INDIVIDUALS

Schizophrenic (more apt to be heterophrenic)

Cyclophrenic (more apt to be homophrenic)

But the above are not sufficient, since the above describe only the types, and the aim of this classification is to provide room for the inclusion of data about the individual. Therefore, for more complete description of the person in question, one must add supplementary data. Thus if one is described as heterohyperdynamic, it means that his capacities are uneven and that some of his capacities are exceptionally good. It is these outstanding capacities that are to be mentioned.

In this scheme of things the types of Jung, Kretschmer and others, also those one meets in life, find their places without any "manipulations." This formula refers to something innate, not to something related to the environment. Nor does it refer to disease

conditions wherein several features usually go together. Furthermore—as we shall see—this formula provides for a line to be drawn between the instance when a trait is a manifestation of a normal function and when this same trait is a manifestation of a psychosis.

It will readily be inferred that the homophrenic is more adaptable. His equipment consists of a greater number of tools for dealing with his environment. In an unfavorable environment he takes things as they come and makes the best of them. The hetero's equipment consists of a smaller number of tools which may be of poor, of medium, or of the best quality (the latter more likely if one capacity develops at the expense of the other). The hetero is, therefore, adaptable to special conditions only. In an environment favorable to his make-up, he is apt to be more successful than the homophrenic of the same degree of dynamia. In an unfavorable environment he either succumbs, escapes (actually or psychically) or gets to work remodelling his environment—depending upon his degree of dynamia. Because of his greater adaptability, the homophrenic is more apt to be a conservative; because of his lesser adaptability, the heterophrenic is more apt to align himself with those struggling for change.

The same is true of social relationships. The homophrenic is in rapport with all whom he meets; the heterophrenic—with a limited group only. In the absence of such a group the hetero may suffer efacement of personality—become an awkward imitator of others—or yield in part only, inwardly keeping aloof and living in a world of his own; or make attempts to change those around him. In this we perceive the difference between the pathological social attitude of the schizophrenic and the social attitude of the heterophrenic in an alien milieu: in the former there is a loss of capacity for rapport with others; in the latter there is a lack of opportunity. Again, either the homo- or the heterophrenic may be naturally asocial.

Homophrenia and heterophrenia, though inherent, may be modified by environment. When hereditary and environmental factors collaborate to accentuate heterophrenia the result may be a distinction in one way or another. On the whole, the hetero is more apt to be characterized by "more-ness": he is apt to hate more, love more, be more altruistic, be more egoistic, more idealistic or more materialistic than the homo. But the latter has more "territory"; his capacities are more extensive than intensive. The homo's char-

acter-landscape is a prairie or, at most, a rolling country; the hetero's—a range of jagged mountains. The homo is more apt to be all that he is inwardly and outwardly; the hetero is more apt to be inwardly different from what he is outwardly, especially when not in a favorable environment, a situation by which he is more frequently confronted.

Thus at the *hypodynamic* extreme we find either—

a) The dull, stolid, frequently heavy, peaceful, banal, slow-moving homo who gives the impression that he has some emotional capacity but is too lazy to be moved, to approve, or to condemn, or even smile; or

b) The rather listless, apathetic, usually lean hetero whose personality seems effaced; who, because of his being in an alien milieu, is shy and retiring; who gives the impression of having no emotional capacity at all—no “guts” in the popular parlance.

At the *hyperdynamic* extreme we find either—

a) The prolix, usually well-rounded, homo who has too many irons in the fire and is all “pep,” mobility and good humor; who is in touch with everyone and everything around him; who is busy “piling job on job”; who is practical, showy, self-approving—the man “with both feet on the ground”; or

b) The usually slender, high-strung, dream-drunk, temperamental intellectual moving in a restricted sphere; now ecstatic and immobile, now in a fever of activity; now in-love now in-hate with people or landscapes; now extremely happy now extremely miserable.

Or the equally familiar tense, wiry, jumpy, over-active business executive who is less showy, more serious and more tenacious than the corresponding homophrenic—the exacting and exact, forceful heterophrenic who is steel-hard with purpose; whose sphere of interests is limited and whose personal contacts are equally as limited by his exacting standards; one whose friendships and hatreds are genuine and enduring.

You may touch up the above characters with whatever additional traits you wish, and you will find them, though changed, true to their types and equally familiar. Suppose you touch them up with ill humor. You will find the hypodynamic ones only a shade different, but the hyperdynamic ones distinctly changed: the stout, grouchy, irritable, fault-finding and quarrelsome homophrenic and the irascible, keen and biting sarcastic heterophrenic who is all

"nerves." Either of them is explosive: but the former is likely to cool off soon; with the later it is a much longer story.

We can see how dementia precox, which is destroying capacities, may augment or obliterate the native psychological features of the patient. If originally homophrenic, he may, after repeated attacks of schizophrenia (which by reducing some may improve other capacities) emerge as a heterophrenic. If originally heterophrenic, he may emerge as an accentuated heterophrenic. Eventually, with the reduction of all his capacities to the same degree, he may, whether originally homo or originally hetero, emerge as a homophrenic of extreme degree of hypodynamia. Those working in state hospitals are familiar with patients of the latter sort and are certain to find this interpretation of their make up as readily acceptable.

We have shown that the facility with which the formula of neurodynamics is applicable, and how it facilitates the understanding of the behavior of the various types of people as individuals as well as social units. For all its roots in the intricacies of the nervous system, this formula is understandable and easily applicable by the layman. As a matter of fact this formula is being used by the layman who easily perceives the difference between the dynamic and the adynamic personality—between the one who has "push" and "pep" and the one who lacks these. And surely, difference in uniformity of capacities is as easily perceived by the layman. In this respect, at least, the layman is a better psychologist than the professional: he does not regard humanity as having its prototypes in the patients of the state hospitals.

BIBLIOGRAPHY

1. C. G. Jung: *Psychological Types*; transl. by H. Goodwin Byrnes; Harcourt, 1924.
2. E. Kretschmer: *Physique and Character*; transl. by J. H. Sprott; Harcourt, 1925.
3. Herbert H. Jasper: *The Measurement of Depression-Elation and Its Relation to a Measure of Extraversion-Introversion*, Jour. Abn. & Soc. Psych. XXV, No. 3, 307-318.
4. C. G. Jung: *Contribution to Analytical Psychology*, p. 302.

THE PSYCHIATRIST LOOKS AT CONTEMPORARY ALCOHOLISM*

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INTRODUCTION

Although most workers in the field of alcoholism feel definitely that alcohol by itself does not produce alcoholism, nevertheless, it should certainly be kept in mind that alcohol is not an inert substance—like water. Pharmacologically, alcohol (at various stages of its effect on the human—and animal—organism) can act as a sedative, hypnotic, analgesic, narcotic, temporary anesthetic, and, in some cases, as a permanent anesthetic, producing death. The uses of alcohol as a relaxer and pain-killer are quite familiar.

Traditions and ceremonies of various types incorporate the use of alcoholic beverages.

Again, in regard to crime, one must keep in mind the following:

(1) Crime is often planned in a place where alcohol is sold.
(2) The tavern is the place where the criminal seeks his accomplices.—(3) The criminal is seldom courageous and uses alcohol to depress his inhibitions and allay his fears.—(4) The spoils of crime are divided often in the tavern.—(5) Alcohol removes from the criminal the element of self-criticism in relation to himself and his acts.

In a scientific approach one considers as the goal of a survey *sound health*—physical and psychological—which is a basic imperative for us all.

The fact that alcoholism is now the subject of medical discussion, of civic forums, and industrial conferences, in contrast to ten years or so ago, when it was not touched upon even in many medical schools, is heartening and disheartening at the same time.

We all would be pleased if this behavior-illness were not so prevalent in our contemporary society. Its repercussions are more varied, and far worse than those of any other specific psychiatric disability. The toll it takes each year in lives, due to accidents; in happiness, due to marital and family-life upheavals, and in ac-

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tual cash value, from the home budget to State and Federal funds is greater than we can calculate; for the intangible aspects of alcoholism are at least as many as the tangible ones.

On the asset side of the increased awareness of and organized interest in alcoholism, are the facts that today nearly everybody recognizes the difference between "social drinking" (even when hangovers are involved) and "alcoholism"; that the alcoholic is a sick person, not just a "bad actor," and that alcoholics as a class are no longer classifiable as "bums" and "drunks." Many of our most intelligent, versatile and useful citizens have alcohol problems. They are, medically speaking, alcoholics, and require treatment for the underlying causations so that they may learn how to live without ever again using this socially acceptable, ever-present beverage, in harmony with themselves and others. The nervous, irritable quality of temperament that, aside from any psychiatric illness, so often underlies the drinking pattern has to be changed into calmer and more tolerantly mature acceptance of disagreeable facts. Treatment, by whatever method, essentially consists in this achievement: of helping an individual change (or strengthen) his personal reactions to the world he lives in and to other people, so that he may abstain from touching alcohol in any form ever again.

Medically, an individual is considered to be an alcoholic if his use of alcohol interferes with one or more of his important life activities, as for example, his job standing and ability, his reputation, his home life. This interference is shown in behavior, in his inability to stop drinking at will, in the fact that alcohol "handles" him; promises, resolutions, even threats are powerless against this domination. In contrast, the social drinker can stop drinking at will. He limits himself to several drinks, except at parties, and even then usually stops short of actually getting drunk to the extent of not knowing what he is doing. The social drinker may, frequently, be injudicious in speech or action, but does not so lose self-critical judgment as to be involved in conflicts, fights with strangers, police, etc.

However, *heavy* social drinkers—and their numbers appear to be increasing—*do* get themselves and others into difficulties; and this group constitutes a danger as an accident risk; also, from their ranks, the chronic alcoholic usually develops. Heavy social drinking, as such, from the medical point of view is, today, more and more a problem and should be dealt with through education and

other measures. It does not, however, constitute alcoholism; although I, for one, certainly feel it can factually be called *incipient* alcoholism; that it should never be dismissed lightly; and that all precautions possible should be instituted to halt and eradicate it whenever it is known or suspected. Many business leaders, professional men, and high-powered executives would be found to be in this medical bracket. With the present world and national stresses subjecting us all to unusual nervous and emotional strain, such individuals are playing with dynamite as they drink their distinguished concoctions.

Furthermore, I am convinced that heavy social drinkers actually cause more trouble, as a group—and this group numbers into the millions—than do the estimated three-fourths of a million alcoholics. The reasons for this personal conviction are based on some 20 odd years' experience in psychiatry and of observing the social climate of "our times." One need not go far for evidence. At any hotel bar or grille you may see at any dining hour a number of well-dressed, presumably influential men who, as the rounds pile up, become louder, more argumentative and expansive in movement. When calm judgment in business or profession is required, alcoholic states of mind are comparable to a cut-off in electricity at the peak hour of production.

I am certainly opposed to prohibitory measures, for they are opposed to the working of human nature and never produce any but poor results. The solution for this heavy social drinking—in which, also, many, many women are participating and which, I believe, relatively few people recognize as a dangerous hazard—might be found in the building of social attitudes against behavior that is inappropriate, stupid, and harmful to others. The drunken driver and the drinking driver are potential killers.

Heavy social drinking, especially in the daytime, produces inefficiency. The executive whose bourbonized judgment dictates a business corporation letter and thereby loses several millions of the stockholders' investments, hurts and harms in a bloodless way. The clerk who, following the patterns set by his so-called superiors, also drinks at the noon-hour and makes typographical or other errors the rest of the day may, as a consequence, be fired. Or, he may mix things up so much that weeks are needed to untangle the matter, causing more work for others, and costing his company many dollars.

Such episodes of "absenteeism-on-the-spot," from the top down, are probably as many as, perhaps more than, those of orthodox absenteeism due to alcoholism.

If, through various opinion-molding media, we could change the prevailing social attitude about heavy social drinking and especially about daytime drinking so that instead of it being considered obligatory, or "smart," even the waiter would look astonished and disapproving, we should all be saved much trouble and, so far as auto accidents alone are concerned, much tragedy. And I do not think the liquor industry would suffer great financial losses. They too have the same problems of inefficiency, alcoholic errors of precision and absenteeism due to alcohol.

So much for social and heavy social drinking.

We have already medically defined an alcoholic as one whose drinking handles him and seriously interferes with his important life activities. But how did he reach such a stage—and what makes an alcoholic? We all know drinking people, even heavy social drinkers, whom we cannot call alcoholics. On the other hand, frequently we treat a patient for an alcohol problem whom the world would never consider an alcoholic, expecting from that term, fireworks and obvious dissipation such as Ray Milland portrayed in "The Lost Weekend." Many a mild-mannered, immaculately groomed man, and woman, highly respected, comes under psychiatric care for alcoholism, who outwardly looks no different from any other "normal" person. These individuals are certainly the hardest to treat and may be called the worst type of alcoholic, because theirs is an insidious, unseen, quiet, almost cancer-like form of drinking. Public opinion is not against them. Their own insight is very poor. They don't do anything "bad." Unless propped, propelled, and pushed by some unswerving relative, this type of drinker continues at large until maybe years pass before, like the one-hoss shay, he falls apart and his actual condition of alcoholism can be recognized. It is then, often, too late to do much, for irreversible organic brain changes have taken place.

In general, one may sum up the making of an alcoholic by the following:

He is a product of his ancestry, the way his grandparents and parents lived, the extent of their drinking, their racial background; of his personal early experiences in life, the inevitable clashes with other personalities, the likes and dislikes, the disciplines, the heart-

aches of childhood and how he did or did not assimilate them; of, also, later experiences in life, from job changes to marriage or love experiences; of religion or lack of religion and basic belief, vague or less vague philosophy; of the social drinking habits of his friends; and of the social pressure to drink occasioned by those habits. This "pressure" is far more prevalent in some lines of work than in others. The average technician, for example, does not have to contend with the demands to "take" a drink that a salesman, especially of industrial commodities, does.

The alcoholic is also a product of his own inner drives or ambitions; and his self-esteem, or sense of prestige, may be so immature that he drinks to assert himself. And always there are biochemical constituents and changes in functioning, so that the psychobiological make-up and *its* changing functioning, undercurrents and intertwines with the individual, with his present life situation and problems (real, or felt to be real), and he consciously or unconsciously takes to the easily acquired habit of taking a drink for a "pick-up." Frequently poor eating and sleeping habits over a period of time affect biochemical functioning so that alcohol is more quickly toxic.

Alcoholism as a psychiatric symptom presents itself like the top of an iceberg. The submerged unseen part is what we have to get a clear understanding of. It is not enough to say, "Don't take any more." Or, "I won't drink any more." The alcoholic, produced by all these factors just enumerated, in varying quantitative and qualitative amounts, is a very sick person whose drinking results from all the inner turmoil and/or rebellion which he attempts to allay and narcotize by alcohol, for him, a drug. Once the alcohol is taken away, the submarine part of the iceberg has to be explored.

Because alcoholism is symptomatic of so many varied personality and behavior disorders, psychiatrists are becoming more and more interested in this serious problem.

The medical definition of an alcoholic—as distinguished from the social drinker—is one whose drinking interferes with one or more of his important life activities. He may lose time from work due to drinking, or the quality of his work may suffer, or his home-life harmony may be disrupted, or he may so speak and generally conduct himself that his reputation and relationships with others suffers. In spite of evidence, clear to other people, that he is

having difficulty with alcohol, he himself usually does not recognize the seriousness of the situation, partly because of the prevailing social attitude that having a drink or two is a usual pleasant custom, an attitude that he has absorbed and that constitutes a form of "social pressure" until he can reach the place—if his brain is intact and his thinking straight—of admitting that just as the diabetic cannot handle sugar, so he cannot handle alcohol without adverse results.

Now, there are many types of alcoholics, and the need for careful discrimination is important both for actual treatment and placement and for a scientific application of the medical statement that alcoholics are sick people. In previous times, those with an alcohol addiction were usually considered as a group to be "hopeless drunks and bums." This attitude still exists in many sections and circles. However, we know it is not accurate, that not all with an alcohol problem are "hopeless" and that many persons with this problem have high intelligence, fine, delicate make-ups and are among our community and social leaders. In the same way, in stating that "alcoholics are sick people" we must break down the generalization. To be of aid to the individual and family, one must first understand that alcoholism is symptomatic of a psychopathological condition, a disorder or illness in the personality functioning; that the pathological condition may be primary or secondary, that physical complications may be in the picture (organic brain damage or deterioration, etc.) and that in order to attempt to treat the patient we must know about his personality make-up, presence of any major psychiatric illness, of any minor psychiatric illness, and about his actual life-setting and circumstances.

Pharmacologically, alcohol depresses the "higher" brain centers, impairing or removing temporarily the brake-power of judgment, discretion, and control. Thus primitive impulses and emotions are set free. Actually, alcohol does not make one "tight"; it makes one "loose."

There are individual differences in so-called "tolerance"—ability to drink without subjective or objective behavior, motor, or other changes; differences also for the same individual, depending on the amount of food in the stomach, emotional situations, fatigue elements, sugar metabolism, and so on; and there are different individual reactions to various alcoholic beverages.

In general, when alcohol is ingested it produces the following physiological changes in functioning:

Poorer coordination of thought and body action; diminished acuteness of sensory perception; delayed or weaker motor performance; more frequent errors in precision work; diminished physical efficiency.

PATHOLOGY OF ALCOHOLISM

Formerly, alcohol was thought to cause heart trouble, kidney damage, and various other organ disorders. There has been little scientific evidence to substantiate these views. Aside from temporary symptoms resulting from an acute drinking bout, such as a thick-coated tongue, bloodshot eyes, and a gastritis of varying degrees, most of the pathological changes are found in disorders in the neuropsychiatric field. Occasionally, cirrhosis of the liver is found, which is associated with depletion in vitamin content, but it is also reported found in as many non-drinkers. Neuropsychiatric disorders include: encephalopathies of various types, neuropathies, and behavior disturbances (psychopathology), evidenced by personality, emotional, or mental deviations from the individual's usual behavior or that commonly accepted as usual by society.

PSYCHOPATHOLOGY

The following are types of reactions in which alcohol plays a very important part in producing the clinical picture. (In most cases these are associated with vitamin deficiencies because of inadequate food intake while drinking.)

(1) Acute intoxication with excitement; (2) Acute intoxication with stupor; (3) Acute intoxication with convulsions; (4) Delirium tremens; (5) Acute and chronic hallucinosis; (6) Mental deterioration and dilapidations; (7) Korsakow's psychosis; (8) Personality and ethical deteriorations; (9) Chronic depressive reactions; (10) Paranoid developments.

PSYCHODYNAMICS

Since alcoholism is a symptom of a personality illness, an emotional disorder or a more serious psychiatric illness or disorder, one attempts through careful examination to uncover the causes and/or psychodynamics producing this symptom, which may be evidence of primary psychopathology or of secondary psycho-

pathology. For purposes of convenience, we can summarize these as follows:

(1) As an escape from painful life-situations; (2) As an attempt to escape from oneself—evidence of maladjusted personalities; (3) As a combination of these two; (4) Evidence of neurosis; (5) Evidence of psychosis; (6) Evidence of feeble-mindedness; (7) Evidence of psychopathic personalities; (8) Evidence of some epileptic conditions; (9) As a result of heavy social drinking, habit, time, body changes and strains of life; (10) As an escape from incurable physical illness.

The individual "psychodynamics" of why people drink is a question now productive of so many answers that the whole issue of treatment including prevention has become rather obscured. Individual motivations for excessive drinking may be summarized as follows:

(1) A self-pampering tendency, which reveals itself in a refusal to tolerate, even briefly, any unpleasant state of mind—boredom, sorrow, anger, disappointment, worry, depression, dissatisfaction, and feelings of inferiority and inadequacy. A childish demand for "I want what I want when I want it because I want it," perhaps expresses the attitude of many alcoholics towards life.

(2) An instinctive urge for self-expression without the determination or staying powers to organize this urge into creative productive action.

(3) A more than usual craving for emotional experiences which call for the removal of intellectual restraint.

(4) Powerful hidden ambitions without the necessary resolve to take practical steps to attain them, with resultant discontent, irritability, depression, disgruntledness, and general restlessness.

(5) A tendency to flinch from the worries and responsibilities of life and to seek escape from reality by the easiest available means.

(6) An unreasoning demand for constant happiness or excitement.

To repeat, alcoholism is felt to be evidence of an escape from reality; or of a maladjusted personality; or of latent or overt homosexuality; or of intense unconscious self-destructive tendencies. We feel that any one of these interpretive conclusions verifies the presence of *anxiety*, *hostility* and/or *tension*; and psychiatric probing by various methods may bring out as their cause:

(1) Some early traumatic event; (2) Disturbing experiences at certain periods of life which the individual's personality was unable properly or satisfactorily to assimilate; (3) Identification and imitation factors, rather than any inherited disposition towards alcoholism; (4) Conflicts causing "pent-up" changes which require narcotizing either the anxiety itself or the anxiety-controls.

So far as treatment is concerned, first, it is known that many alcoholics have been able to stop drinking via many so-called approaches. Some stop by themselves, unaccountably, or "for some reason or another"; others stop because of a religious experience or conversion; others by and with the aid of social workers. Some stop drinking with help from lay therapists; some, from lay groups; and others, from lay and religious groups, for example, The Salvation Army.

Even the old "Keeley Cure" helped many alcoholics and some are now advocating a conditioning treatment without psychotherapy; while many, with deeper interest, use the conditioning, or aversion, treatment in order to get a beachhead on the patient and then follow up with psychotherapy.

Psychoanalysis alone, hypnosis alone and hypnoanalysis alone have all been quite unsuccessful.

From the medical psychological and psychiatric point of view of treatment, each individual presents an individual problem and must be handled as such. However, in general, the methodology can be described as follows:

First of all, one wishes to determine what type of psychiatric problem one has to deal with; how much deterioration is present; how serious is the extent of the drinking; whether the individual really wants help.

Remembering that a man or woman with an alcohol problem may come or be brought in any stage from that of acute D.T.'s to that of the remorseful hangover period, one should deal practically with the problem at the time. The method of selection follows the general lines enumerated below:

(1) The individual who desires to abstain but who is unable to do so by himself. This patient has good intelligence, some maturity in his make-up, and his life habits and contacts indicate stability. This type is to be handled by extra-mural or office therapy of regular, frequent visits which are the patient's responsibility to keep, and sedation as indicated.

(2) The individual who desires to abstain but who is unable to do so by himself. This patient has good intelligence, some maturity in his make-up, but his life habits and contacts are poor. He should, therefore, be placed in a non-institutionalized farm arrangement, where psychotherapy, including help and guidance away from his contacts, is started.

(3) The individual with good intelligence and rather immature make-up who should abstain but does not desire to do so. Most in this group have poor habits and contacts, although some do not. This type should be placed on an alcohol farm, sanitarium, or Hospital under the Inebriate Act, for a definite period of time.

(4) Korsakow's psychosis and alcoholic deteriorated patients should be treated in mental hospitals permanently.

(5) Individuals with delirium tremens and acute hallucinosis should be handled and detoxified in the office equipped and prepared to do so, or placed in acute psychopathic hospitals and then studied in the way described for future handling.

(6) Feeble-minded individuals with a history of repeated arrests, commitment to the workhouse or house of correction should, after careful examination, be handled by the penal system.

(7) Chronic alcoholics should not, of course, be treated in general hospitals, which are not equipped to handle this problem, where treatment is usually mere desaturation and discharge at a time when the individual is psychologically demobilized and ready for another bout. This pattern of acute intoxication, brief desaturation period and resumption of drinking, is easily established and leads with more or less rapidity to involvement of the central nervous system. It is felt that this type of superficial therapy has contributed to a great deal of the fatalistic attitude of some lay and medical groups about treatment of alcoholics in general, and to the feeling that "all drunks are hopeless."

This method of selection is based on data obtained from the patient and/or members of his family, social service or other agencies. As in any psychiatric examination, one needs to know all the important life details and facts. With the non-intoxicated, non-deteriorated patient, who may be interviewed in the office, or at the hospital after he has cleared up from the effects of drinking, a complete history is taken from birth to the present. This should include the patient's place in the family group; developmental data; the presence or absence of disturbing behavior or situations

in childhood, adjustment to school, vocational record, marital status, sexual activities and attitudes, religious habits and feelings, financial status, family situations, general health throughout life (including details of major illnesses or operations or accidents), and a close survey of the present life situations and persons involved.

A psychiatric examination also includes formal mental status of general behavior and habits, activities, mood, special preoccupations, sensorium and intellectual resources, and insight. To determine the presence of any organic pathology, a physical and especially a neurological examination should be made, with specific laboratory tests as indicated. A member of the family, or close friend, should be interviewed in order to obtain objective data about the drinking problem, drinking behavior, and general personality of the individual, with emphasis on his assets and good qualities as much as on the difficulties his drinking has caused. (The examination should also include personality depth-studies through use of the Rorschach analysis or the Murray Thematic Apperception Test. The sensorium and intellectual resources are further tested by the Kohs Blocks test, the Wechsler-Bellevue Adult Intelligence Scale, Electroencephalograms, and other tests as indicated.)

Based on all these findings, one should prepare a more or less detailed summary of the patient's assets and liabilities to aid in understanding and treating him as an individual. A similar examination-interview with the mate is important to help find out how great a part, if any, the friction of personalities has played in contributing to the production of strains or out-and-out irritants that the individual sought to escape via drinking.

TREATMENT

No one who has had an alcohol problem can ever again drink "socially." Science does not yet know exactly why this is so—what change has taken place in cell tissues to make this impossible, but pragmatic experience has proved beyond doubt that once a person's drinking has crossed the line into pathological drinking, he can never "handle alcohol" again. He can reintegrate his personality and often achieve more than even in the early, "social drinking" days; but he must be a total, permanent, forever-after abstainer.

These facts must be bluntly stated at the outset, and accepted by the patient if desired results are to be expected. Frequently it is possible to modify poor vocational adjustment, or irritating marital situations involving sexual incompatibilities, parental conflict over the management of children, etc. The patient himself may not be conscious of the strains of all these things upon him. When it is not possible to modify the situation, it is often possible to change the patient's attitude toward the difficulties he has to meet. Many a person becomes morbidly self-accusatory and fatalistic because of what he considers his failure to modify the unmodifiable. Such an individual may be greatly helped by mutual discussion, constructive criticism and wise guidance.

The goal of treatment therefore is to teach the individual who can be helped, to learn how to live without ever again using alcohol in any form.

This involves usually a rather lengthy rehabilitation period of habit-training, re-directions in life, and helping the patient to learn intellectual control over mood domination. Individual therapeutic interviews utilizing the principles of ventilation and desensitization on a distributive analytic basis help give the individual a chance to let off steam and react less strenuously to previous upsetting situations or conflicts, and also give him insight into some of his modifiable drives and attitudes that caused him difficulty. He is indirectly taught to accept tolerantly and maturely other people's personalities without feeling unnecessarily "blocked" or frustrated, and a careful appraisal of his personality liabilities and assets helps him to reorganize his views and values and goals and capacities along more constructive, satisfying productive lines.

We must always remember that while many individuals drink to relieve various feelings of discomfort or psychic pain, others drink as part of a more serious psychiatric picture involving mood-swings or schizophrenic features, etc. The need of thorough examination, and understanding of the underlying personality illness or disorder cannot be over-emphasized.

For all these reasons, interviews with the husband or wife or family members assume major therapeutic importance. Many a poor result of treatment is attributable to lack of any insight whatever on the part of those closest to the patient; they too must learn to accept unmodifiable facts of life and to utilize principles of emotional hygiene in their interpersonal relationships.

SUCCESS IN TREATMENT

Experience with alcoholic patients indicates that successful results are accomplished by the following factors:

(1) Careful selection of patients: that is, those who desire to learn how to stop drinking, who have average or better intelligence, some level of emotional maturity, undamaged brains, with place of treatment depending on their business, home, social contacts, etc.

(2) Personality of the psychiatrist, who should be plastic, sympathetic, tolerant, but firm. (Ideally it is important for the psychiatrist and staff-members to be total abstainers.)

(3) Distributive analysis and psychotherapy with personality discipline, re-education, desensitization and ventilation.

(4) Adjunctive vitamin and/or insulin therapy in controlled dosage, to aid in the biochemical functioning.

(5) Interpersonal relationship of patient and therapist.

(6) Suggestive influences, including community and civic activities.

(7) Interviews with the mate or family members.

(8) Full cooperation of the patient and his associates.

(9) Intensive follow-up for a period of many weeks, and continuous follow-up for life, by means of correspondence, phone calls, annual visits, etc.

PREVENTION

On a broader basis, alcoholism now constitutes a major national health problem, all workers in public health and welfare agreeing that all too frequently alcoholism is one of the outstanding factors in the production of serious difficulties for individuals and the community. As one example, many a juvenile delinquent comes from a home broken up by the effects of alcoholism.

The need for preventive education and understanding is great. Recently much more attention has been focussed on the problem of the alcoholic individual and in many states and cities, committees have formed to handle or attempt to handle this problem. Because the serious implications of alcoholism lie in the field of behavior, medical psychiatric supervision is needed to properly guide individuals and groups desirous of "doing something about" alcoholism.

It is important to keep away as much as possible from emo-

tional, political, or other attitudes that might obscure the clear fact that treatment of the alcoholic himself is primarily a medical rather than a moral problem. Wise preventive education should consist of recognizing that, in general, excessive dependent drinking is a frequent result of poor unsatisfactory emotional and other life-habits apparently associated with some of the contemporary social pressures of speed, noise, change and general insecurity in nearly all spheres of life. The use of alcoholic beverages is traditional in most parts of the world and previous attempts at regulation have failed to get at the root of the problem because it is inherent with the individual himself, his personality, and the specific life-setting with all its frustrations, frictions, etc. in which he finds himself.

We feel, therefore, that information centers where problems of alcoholism could be referred, associated with treatment facilities to handle acute problems (a psychiatric hospital or unit) and adequately staffed with trained personnel (psychologists, nurses, social service workers) under the supervision of a psychiatrist offer the most practical working program for the community and the individual. Affiliated services would include farms where selected patients could receive psychotherapy and common-sense reeducation in life; and protective institutional arrangements for the more seriously psychiatric types, including the feeble-minded and psychopaths—the latter constituting, of course, the most difficult rehabilitation problem.

In conclusion, alcoholism is a serious national health problem and it is also a social problem requiring new and different social attitudes about excessive uncontrolled drinking. The alcoholic is a sick person who needs competent proper medical and psychiatric care, treatment, and follow-up supervision. The only possible goal for the alcoholic lies in his never again taking a drink. The only possible goal of treatment, along whatever lines, therefore, is the well known fact of total permanent abstinence for the ex-alcoholic. The ex-alcoholic should not be made to feel, either in the home or community, that his illness was a crime. He should be given every possible proof of moral support in maintaining his health and the same sort of consideration—no more and no less—than an ex-T.B. patient receives.

To aid in the prevention of alcoholism, greater stress on sound physical and mental health habits and on the emotionally impor-

tant elements of family and religious life, with lessened pressures of speed and dollar-sign success would, we feel, help decrease the production of many emotionally immature, early neurotic, early psychotic, and incipient alcoholic personalities. One need not enumerate today, the terrific sociological pressures upon every one of us, and the consequent need to maintain health in all ways.

From the practical standpoint, prevention and treatment both, would be best organized and instituted to serve the community through:

(1) Information centers (similar to those maintained by our T.B., Cancer, Rheumatic Heart Associations) where material could be obtained by the public and through which contacts with medical and psychiatric set-ups could be made.

(2) Through, factual course on alcoholism, its treatment and prevention, given in all our medical, nursing, and social service schools.

(3) A hospital or section of it in every state where patients with alcohol problems could be properly treated and given the medical-psychological service they require.

(4) State Hospital set-ups for the treatment of some alcohol patients.

(5) State Farms where physical rehabilitation and social psychiatric help under the supervisions of a psychiatrist would be available.

(6) Extra-Mural Clinic centers, located near the alcohol hospital or information center, to serve as a diagnostic unit, treatment unit, social service unit, and training unit for workers in this field of behavior illness.

(7) A concerted program of education against *heavy* social drinking, beamed at the reading and listening public—including the teen and twenty agers—and supported as a Public Health Service.

THE KINSEY REPORT*

Book Review and Roundup of Opinion

Professor Kinsey's *Sexual Behavior in the Human Male* is the dream of a sexologist come true; a dream at least in its conception and initial execution. Freud and Stekel have probed more deeply, but no one has covered so wide an area. The sheer volume of Kinsey's information, the immensity of its scope and the solidity of its backing are overwhelming. Kinsey is indebted for his data to the confessions of 5300 white males of Canadian and American extraction. Actually 12,000 histories, male and female, white and colored, gained in intimate personal conferences, contribute to this amazing survey of the sex outlets of the genus *Americanus*. Since the study is confined to the United States of America, the title has been called "misleading." This is unjustified. Kinsey distinctly speaks of sexual behavior *in*, not *of* the human male. Therefore, the title would be appropriate even if the author had limited himself to a small group. It so happens, however, that he covers far more territory than any other student who made similar inquiries. Kinsey's interpretations are, of course, colored by specific American mores and traditions, but since the American is a composite of all races, many of his determinations may well apply to humanity at large.

This present volume marks only the first stage of Kinsey's studies. He contemplates a Twenty-Year Plan, stipulating minute examinations through personal interviews with 88,000 more individuals of every social, racial and religious category to complete his gigantic task. It is to these present and future contributors that Kinsey dedicates the first fruit, the result of nine years of concentrated labor by himself and his able collaborators. The next volume will delineate the sex life of women. Others will deal with legal aspects of sex behavior, the sexual factor in marital adjustments, the heterosexual-homosexual balance, sexual adjustments in institutional populations (schools, prisons, barracks), prostitution, sex education and other specific problems. It is to be hoped that these future studies will supply some of the informa-

* Alfred C. Kinsey, Wardell B. Pomeroy, Clyde E. Martin: *Sexual Behavior in the Human Male*. W. B. Saunders & Co., Philadelphia and London, 804 pp., \$6.50.

tion that the present volume lacks; for instance the great role that paraphilias, so-called "perversions", like sado-masochism, and especially fetishism, play in the sex life of man. Understandable reticence on the part of the subject may make it difficult to procure data along these lines. More than minimal figures can hardly be expected. The exemplary and altogether admirable index does not contain the term "sadism" at all and has only one single reference to "fetish."

Kinsey's work has been criticized for omitting data on sexual-anatomical conditions and abnormalities but since the book deals with *behavior* this criticism seems misplaced. Kinsey does have data on this aspect of sex and they will be the subject of a separate publication. It would be most helpful and constructive if certain correlations between behavior and organic states could be investigated together with behavior. This reviewer has reference, for instance, to the possible relationship between frequencies of sexual outlets and prostatic hypertrophy, or of the level of sex energies and activities to premature baldness. Do men who undergo prostatectomy, have indulged habitually in sexual excitement without orgasm? On the other hand, do men who have no prostatic difficulties in later life, usually induce an orgasm whenever there is erection and congestion? Does an excess of male hormone, as a great sexual activity may indicate, tend to produce baldness? (Eunuchs are never bald.) Do homosexuals, especially those with female characteristics, become as often prematurely bald as purely heterosexuals? No study ever undertaken before has offered such a golden opportunity to answer these questions.

Kinsey's astonishing success and the wide acclaim of his book, should gratify every student of sex. It is a symptom of progress, most encouraging to every scientifically minded person. It would not have been possible without the author's stern scientific method and motivation.

A Professor of Zoology and author of authoritative biological text-books, Kinsey devoted eighteen years of his life to a meticulous study of that modest insect, the gall wasp. He brings the same academic detachment, the same objective analysis and the same patience to bear upon the sex life of our species. His inability to answer important queries on sex by his classes in biology, prompted Kinsey to undertake his perilous study. In the beginning his researches met with considerable opposition, but the Uni-

versity of Indiana stood staunchly behind him. His scholarship eventually won the unstinting support of the Committee on Research on Problems of Sex of the National Research Council and the Rockefeller Foundation. Sex is becoming respectable! "Certainly," remarks Dr. Alan Gregg, speaking for the medical division of the Rockefeller Foundation in a brief but eloquent preface, "no aspect of human biology in our current civilization stands in more need of scientific knowledge and courageous humility than that of sex. The history of medicine proves that in so far as man seeks to know himself and face his whole nature, he has become free from bewildered fear, despondent shame, or arrant hypocrisy."

"These studies," Gregg continues, "are sincere, objective, and determined explorations of a field manifestly important to education, medicine, government, and the integrity of human conduct generally. They have demanded from Dr. Kinsey and his colleagues very unusual tenacity of purpose, tolerance, analytical competence, social skills, and real courage. I hope that the reader will match the authors with an equal and appropriate measure of cool attention, courageous judgment, and scientific equanimity."

Sexual Behavior in the Human Male is, indeed, a scientific Book of Revelations, accepted as such, in spite of its stunning disclosures, by scholars and laymen alike. Lincoln freed the slaves from their shackles. The work of Kinsey and his collaborators should be a powerful factor in freeing human society, from fantastic tribal taboos, from ecclesiastic prejudices, and from the savagery of medieval laws. This may indeed be known as the "Alfred C. Kinsey age."

Kinsey freely acknowledges the merits of previous investigators. The shadow of Freud appears on every page, and the authors are also fully familiar with Stekel. Kinsey has one great advantage over the psychotherapist and the psychoanalyst—his specimens are not neurotics, psychopaths, or psychotics in the meshes of emotional and social conflicts or legal entanglements, but average men, who are encountered daily on the street or the bus. Aside from Freud and Stekel and many more students of sex, Kinsey pays tribute to Havelock Ellis, Hirschfeld, Mantegazza, Marcuse, Moll, Bloch, Rohleder and other pioneers in his special field.

"But," as he points out, "none of the authors of the older studies, in spite of their keen insight into the meaning of certain things, ever had any precise or even approximate knowledge of

what average people do sexually. They accumulated great bodies of sexual facts about particular people, but . . . they never knew what things were common and what things were rare, because their data usually came from the miscellaneous and usually unrepresentative people who came to their clinics. . . . None of the older authors, with the possible exception of Hirschfeld, attempted any systematic coverage of particular items in each history, and consequently there was nothing to be added or averaged, even for the populations with which they dealt."

Kinsey's book widens the horizon of every student of sex. Some chapters, especially the first four explaining his method and validity of his data, are highly technical. Others summarizing his findings, should be required reading for every physician, every sociologist, every legislator, every educator, every judge, and district attorney and every parent.

"Viewed objectively," Kinsey holds, "human sexual behavior, in spite of its diversity, is more easily comprehended than most people, even scientists, have previously realized. The six types of sexual activity, masturbation, spontaneous nocturnal emissions, petting, heterosexual intercourse, homosexual contacts, and animal contacts, may seem to fall into categories that are as far apart as right and wrong, licit and illicit, normal and abnormal, acceptable and unacceptable in our social organization. In actuality, they all prove to originate in the relatively simple mechanisms which provide for erotic response when there are sufficient physical or psychic stimuli."

The Kinsey approach to individuals is patient and tactful. He wins their trust by his candid approach, convinces them that he harbors no prejudices and that the data he collects and registers in an intricate code to which no written key exists, are as inviolate as the confidences of the confessional.

He states frankly and charmingly that there were few people whom he did not like better after he had heard their story than when he met them, no matter what the revelations were.

It takes Kinsey a year to coach trained scientists, until they understand his method and know his code. He would rather destroy all his accumulated data than reveal one confidential report. He even resists the temptation of rendering his advice, where both husband and wife have answered his three hundred questions, though a word from him might salvage a marriage.

Wherever possible, Kinsey attempts to get a hundred percent reply from any specific group. In this respect he has been most successful with college men. He and his associates do not hesitate to spend thousands of hours in penitentiaries, until they win the confidence of inmates. No den of prostitution is too low, no gilded palace too high for his patient survey. There is no level of society which he has not penetrated, no state of the Union where he or his emissaries have not gathered knowledge. And yet he is still 88,000 histories short of his ultimate goal. He is not, for instance, prepared to make any statement on the sex pattern of the colored race, because so far he has intimately examined only two thousand colored men. . . .

It is, of course quite possible, even probable and freely admitted, that subsequent studies may modify some of his figures. Among the persons interviewed there are undoubtedly some "show-offs" who exaggerate their exploits, but catch-questions and occasional rechecks enable Kinsey to spot the exhibitionist and the braggart. The tendency to indulge in sexual fantasies, even under scientific scrutiny, is offset by what Kinsey calls "the cover-up" the unwillingness of persons of certain ages and certain social levels to reveal socially condemned practices.

One of the most astonishing findings of the Kinsey group is the existence of different sexual patterns on different social and educational levels. Men who have only attended grade schools, men who have attended or completed high schools, and men in the college level evince surprising variations in sexual behavior. In the lower levels, there is less petting to the point of ejaculation and less kissing, but more fornication and the percentage of masturbation, after adolescence, is lower. The high school level stands between the two. In both the lower and the mid-level, homosexuality is more freely admitted than in the upper level. Innumerable charts and statistical tables explain and interpret these findings.

Masturbation, generally recognized as a biological necessity and a harmless expedient by the educated class, is admittedly the chief outlet of 60% of the men in the college level until marriage. Before adolescence it is almost universal. Mantegazza once said that if an inhabitant of Mars wanted to characterize this world in one word he would call it "a world of masturbators." Kinsey does not quite accept this view. 92% to 97% of all males admit masturbatory experience. 69% of males in the college level, 42% of high

school level and 29% of grade school level carry masturbation for shorter or longer periods into their married life.

Kinsey agrees that indirect mental harm may result from autoerotic practices, as a result of conflicts introduced by false and foolish condemnation. "In the present study," he says, "we have examined the histories of 5300 males, of which about 5100 record experience in masturbation. It would be difficult to show that the masturbatory activities have done measurable damage to any of these individuals, with the very rare exception of the psychotic who is compulsive in his behavior. On the other hand, the record does include thousands of cases of boys living in continual conflict, fearful of social disgrace, oftentimes disturbed over the effect of such behavior on their ultimate sexual capacities, occasionally attempting suicide—as a result of the teachings concerning masturbation. For the boys who have not been too disturbed psychically, masturbation has, however, provided a regular sexual outlet which has alleviated nervous tensions; and the record is clear in many cases that these boys have on the whole lived more balanced lives than boys who have been more restrained in their sexual activities. The resolution adopted at an American Medical Association convention in 1917 asserting that there is no evidence that abstinence from sex activity is inconsistent with the highest physical, mental and moral 'efficiency' would be questioned by most clinical psychologists and psychiatrists today, and is definitely contrary to the findings in the present study."

Homosexual outlets are most frequent or more readily admitted in the lower levels. The social taboo against these practices is still too potent for complete candor. On the other hand a surprisingly large percentage of men admit the continuance not only of masturbation but also of homosexual relations after marriage.

In spite of the antiquated penal code and the condemnation of homosexuality by the Judeo-Christian tradition, 37% of all men in all classes, that is to say, more than one in three admit homosexual experience to the point of orgasm after maturity. 50% of all men who are not married at the age of 35 admit some homosexual experience. "Since," Kinsey explains, "only 50% of the population is exclusively heterosexual throughout its adult life, and since only 4% of the population is exclusively homosexual throughout its life, it appears that nearly half (46%) of the population engages in both heterosexual and homosexual activities, or reacts to persons of both sexes, in the course of adult lives."

Kinsey provides an interesting table from 0 to 6 to determine shadings between heterosexual and homosexual, a "zero" being entirely heterosexual and a "6" entirely homosexual. In view of the data which we now have on the incidence and frequency of the homosexual and in particular of its co-existence with the heterosexual in the lives of a considerable portion of the male population, Kinsey insists, "it is difficult to maintain the view that psychosexual reactions between individuals of the same sex are rare and therefore abnormal or unnatural, or that they constitute within themselves evidence of neuroses or even psychoses."

Magnus Hirschfeld proclaimed the existence of the "intersexes" but was unable to prove his point statistically. Kinsey's findings, unless materially altered by subsequent surveys, seem to be final. "Males," he declares, "do not represent two discrete populations, heterosexual and homosexual. The world is not to be divided into sheep and goats. Not all things are black nor all things white. It is a fundamental of taxonomy that nature rarely deals with discrete categories. Only the human mind invents categories and tries to force facts into separate pigeon-holes. The living world is a continuum in each and every one of its aspects. The sooner we learn this concerning human sexual behavior the sooner we shall reach a sound understanding of the realities of sex."

About 35% of men questioned by Kinsey and his collaborators, admitted extramarital relations. The great cover-up on this point, however, makes the probable figure higher—45 or 50% (or more?). The human male, like most mammals, Kinsey suggests, would be completely promiscuous, except for social and legal restrictions. Astonishing to the psychoanalyst is that 60% of the college level admit "mouthgenital" contacts. And slightly over 17% of our rural male population play with animals. An equal number admits sexual contact with animals to a climax.

Even the psychoanalyst may be amazed by the prevalence of sex deviations in the average individual. His preoccupation with patients may lead him to the conclusions that certain deviations are "abnormal." Kinsey, like Guyon whose remarkable volume on *The Ethics of Sexual Acts* has just been republished by Knopf, finds it impossible to draw a distinction between "normal" and "abnormal" acts. The "abnormality" is due to our conventions and not due to nature. Both men have a field of vision that extends far beyond the walls of the hospital or the consultation

room, because neither of them is a medical man. From some points of view, this is an advantage. It frees them, to some extent, from the traditional blinders. "Even the scientific discussions of sex," Kinsey holds, "show little understanding of the range of variation in human behavior. Present day legal determinations of sexual acts which are acceptable, or "natural" and those which are "contrary to nature" are not based on data obtained from biologists, nor from nature herself. On the contrary, the ancient codes have been accepted by laymen, jurists, and scientists alike as the ultimate sources of moral evaluations and of present-day legal procedure." Normal and abnormal Kinsey suspects "are terms which a particular author employs with reference to his own position on a continuous curve of various sexual levels and activities. This, in spite of the fact that these codes represent analyses made by mystics two or three thousand years ago."

Infantile, and pre-adolescent sexuality are no longer a controversial issue. While certain actions of the infant, may be merely mechanical explorations of his or her body, no one can doubt after Freud and the statistics of Kinsey that sex begins in infancy. "Freud and the psychoanalysts contend that all tactile stimulation and response are basically sexual and there seems considerable justification for this thesis, in view of the tactile origin of so much of the mammalian stimulation. . . . Adult behavior," he goes on in turn, "is more obviously a product of the specifically genital play which is found among children, and on which we can now provide a statistical record. Our own interviews with children younger than five, and observation made by parents and others who have been subjects in this study, indicate that hugging and kissing are usual in the activity of the young child, and that self-manipulation of genitalia, the exhibition of genitalia, the exploration of the genitalia of other children, and some manual and occasionally oral manipulation of the genitalia of other children occur in the two- to five-year-olds more frequently than older persons ordinarily remember from their own histories." "Some of the play in the younger boy occurs without erection, but some of it brings erection and may culminate in true orgasm."

Boys in their teens are more active sexually than most medical observers suspected. The weekly number of ejaculations is greater in the teens up to nineteen than in any subsequent period of life.

On all these subjects, Kinsey's statistics and graphs are illuminating and convincing.

Kinsey does not see eye to eye with the Freudians on certain phases. Like Guyon, he finds the existence of repression, but hardly any evidence of "sublimation." Religious training may check certain sexual deviations, but it also reduces the total sexual outlet. Active Catholics, active Protestants and orthodox Jews are somewhat less active sexually than those who have abandoned the churches and synagogues, but the grand lines of the sexual pattern remain unalterable. They are drawn not by religious precepts and legal statutes, but by Nature herself.

Kinsey's book is like an atom bomb to shake educators and parents out of their complacency and their often mischievous meddling with the evolution of sex. We may draw the cheerful note from Kinsey's studies that the world is not going to the devil. The present generation behaves sexually exactly like their fathers, except that the sons are more candid.

Prostitution according to Kinsey's figures plays a comparatively small part in the sex life of the American male, especially in the higher levels. We may conclude therefore that suppression of known places of prostitution is evidently often successful. The price we pay for such success in the form of a wider dissemination of venereal diseases, of rape, seduction and abortions, of homosexual behavior of a high divorce rate etc. is great indeed. But such is always the case when safety valves are being closed and conventional prejudices defeat logic and common sense.

Petting to a climax is a substitute most favored by the college group. Presumably a similar inquiry in countries, where prostitution and premarital relations are more or less sanctioned, would give a somewhat different picture than Kinsey's survey. It is to be hoped that Kinsey will extend his studies to other countries or that other Kinseys in other lands will take up his trail.

In any event Kinsey's work is invaluable as a guide and book of reference. We now know that nearly 95% of all Americans indulge in some sexual activity forbidden by law. Fornication itself is a penal offence in most states. There are not enough jails to hold 95% of the population. We are not certain that the remaining 5% may not deserve jail too for some other real or meretricious offence. Kinsey's book should give all psychiatrists and doctors and leaders of men the courage to demand a change in our

laws and a new and more realistic orientation of our morals. Without minimizing the domination of the sex instinct by the mind, a greater naturalness is imperative for a better world of tomorrow.

HARRY BENJAMIN, M. D.

New York, N. Y.

Dear Editor:

I have watched and observed Dr. Kinsey's work for many years, having been keenly interested in his findings and results. I consider it a Research Magnificent. Does it apply to the entire human male population of the United States? Of course, it does not. Dr. Kinsey himself pointed out that his report is merely a tentative, approximate one; he is continuing his studies and will accumulate much larger number of data. Are all his statistical data accurate? Perhaps not. Perhaps after more interviews he will change some of his testimonies and percentages. To me, the greatest value of the book lies in the fact that it was published; that it has been bought in such large quantities, although it does not contain pictures. The fact that we are able to discuss this problem so openly, that the Y.M.C.A.'s, Ladies' Clubs, church organizations send out invitations for speakers to interpret Kinsey for them, is of outstanding value. (Part of the discussion of Dr. Kinsey's paper on "Comparison of Sexuality in Male and Female" read before the Association for the Advancement of Psychotherapy on April 9, 1948.)

ABRAHAM STONE, M.D.

New York, N. Y.

Dear Editor:

Having spoken extensively on the subject at the recent convention of the American Psychopathological Association, the proceedings of which will be published separately, I will limit myself here to mentioning some of the main points of my discussion.

I shall be brief regarding the positive points of my evaluation of the Report. They are too patent and widely known to be dwelt upon at any length. It is obviously of great scientific value to find the confirmation of the important discoveries of Freud which revolutionized our science of human sexuality, obtained for the first time by observations on a very large scale. Such facts as the early beginnings of infantile sexuality, its relative independence from

the hormonal and genital development, its diffuse polymorphous character bringing it into close resemblance to various perversions, all those facts are well known to the clinician, but continue to shock the prudish and the inexperienced. Therefore, it is not only of scientific but of great educational and social value that observations on a large scale permit Kinsey to challenge an entire body of social, legal and cultural prejudice interfering with our evaluation of sexual behavior. In this way Kinsey becomes a real crusader for truth in the best American tradition.

However, our deep appreciation of Kinsey's studies can not blur the eye of the clinician to its serious weaknesses. Some of them seem to be a natural consequence of his crusading spirit, others are inherent in his behavioristic methods of investigation. The clinician must part ways with Kinsey when he comes close to considering homosexuality as just another variety of behavior which in itself does not preclude a harmonious and a well-integrated personality. This conclusion is based on two characteristic errors. Firstly, no difference is made between homosexuality as an accidental sexual outlet and homosexuality as a minifestation of a general distortion of the personality. Secondly, Kinsey implies that a homosexual pattern of behavior may be something independent from the rest of the personality. Clinical observations show that the personality of most homosexuals is deeply disturbed and this for deep psychological reasons and not just because of the pressure exerted on them by a prejudiced public opinion. A purely behavioristic method of investigation without any concern for the total personality and for psychological, especially unconscious, motivations leads Kinsey, a serious scholar, to some quite naive statements such as for instance that "the introduction of the homosexual male to a heterosexual experience should come through friendships which lead to affections and spontaneously erotic development."

Another important chapter indicating the shortcomings either of the behavioristic method as such or of the authors of the Report are the remarks on sublimation. The Report defines sublimation, contrary to clinical observation and theory, simply by its negative characteristics that is by the lack of direct sexual gratification. Moreover, Kinsey confuses neurotic symptoms and repressions with sublimation, that is with the ability to divert sexual energy toward non-sexual goals and objectives in such a way as not to restrict the ego in its expansion and not to produce morbid symptoms. Clin-

cal experience not only shows that such a highly desirable process is possible, but also point to its specific sources, mechanisms and complications.

The concept of total sexual output is certainly misleading from the clinical point of view, since identical manifestations have in different individuals entirely different significance. Thus masturbation, practiced by an adolescent or by a lonely man for various reasons, can not be compared to compulsive masturbation forming a part of a sexual outlet of a married man. Various forms of promiscuity may indicate various disturbances of total personality and certainly do not necessarily mean originally greater libidinal needs. The same holds true for various forms of sexual frigidity or, as Kinsey calls it, "apathy" which can not be differentiated on the basis of purely behavioristic observations. In particular, the frequent clinical combination of promiscuity and frigidity in women or the split between love and sexual desire in both sexes demonstrates most conclusively the psychic patterning of sexual behavior.

To conclude, it seems to this writer that the complexity of human psychosexuality does not justify a purely behavioristic approach, which, whatever its great merits, should be supplemented by clinical, especially psychological methods of investigation.

GUSTAV BYCHOWSKI, M.D.

New York, N. Y.

Dear Editor:

Kinsey's book on the "human" male in reality deals with the "American" human male. Although there is much in the book which may be applicable to the male the world over, I think this point should be kept in mind. I wonder whether in the course of his studies Kinsey will extend his investigations to other cultures, races and nations, including the savages of various continents. Anthropologists and psychoanalysts have attempted to shed light on the social and sexual life of the primitives. It may be worthwhile to compare notes with them.

HILDA STEKEL

London, England.

Dear Editor:

I believe Kinsey has collected a great deal of material concerning sexual behavior in our culture. Much of the information he

has gathered confirms the observations of psychiatric clinicians in many points. For instance, he showed the overt expression of sexuality in children at an early age, the influence of education and of different cultural standards on sexual behavior, but most emphatically he showed the great variety of sexual practices in the general population, practices which were considered by many people as "perversions." We believe the factual evidence gathered by Kinsey in his Report cannot be assailed. The objection of some critics is probably valid that some of the subjects in the Kinsey Report falsified their statements retrospectively. The amount and type of sexual activities was probably different years before the interview, and did not correspond fully to that which they related later. It is, therefore, possible that some quantitative performance scores are too high. On the other hand, the critics forget that quite a number of people were questioned about their sexual activities at the time of the interviews. In other words, a large number of statements by different age groups were made not in retrospect but concerning the present.

As I mentioned before, the factual material which Kinsey gathered will stand; it does not differ from the material gathered beforehand, on individual cases, by psychiatrists. The statistical support, however, Kinsey gives to prior observations is very impressive. The criticism which will be leveled against the Kinsey Report will be not so much on the factual material but on the interpretation of the facts obtained. Kinsey not only presents the material he collected but also tries to interpret sexual behavior. His basic attitude is that if we divest sexual behavior from moral interpretations every sexual behavior becomes legitimate. Variations in sexual habits can be considered as biological variations, similarly as height, weight, hair color or any other biological attributes, where there are many transitory forms between two extreme poles. Therefore, Kinsey believes that actually no sexual pathology exists, only expressive variations which are different in different civilizations and even in different groups comprising a particular civilization.

We believe that in interpreting sexual behavior this way, Kinsey has limited himself to the "actuarial" aspects of sex behavior and has not entered into a consideration of the individual dynamics. It was known for a long time that the majority of the population displayed at times sexual behavior which could have

been considered "abnormal"; actually, all sexual practices are used by the majority of the population which are also practiced by that minority whom psychiatrists, consider not well adjusted. The difference is not in the behavior, because both the majority and the minority do the same, but in the motivation and (which we think is even more important) in the adaptability of the majority as compared with the non-adaptability of the minority. For instance, homosexual experimentation by the majority is incidental. The majority is able to perform in a heterosexual way and is flexible in its sexual expressions and adaptations. A minority, however, is only able to perform in one particular way and does not get, and cannot get, gratification in any other way. They are obsessively set on a particular form of sexual behavior. This dependency on a particular form of sexual behavior, motivated differently in different people, puts the minority group apart from the majority. How such a dependency develops is not yet fully clear, and much research will have to be done on that score. The delineation of the majority behavior from the minority will be our next task. The Kinsey Report will stimulate this process very much. I hope it will free sexology not only from moral stigmatization but also from prejudiced theoretical encumbrances which are prevalent in many psychiatric schools of thought. However, the fact will remain that even though phenomenologically sexual expressions look alike and therefore can be treated statistically alike, nevertheless, the causative factors behind these similar-looking behavior patterns can be quite divergent.

PAUL H. HOCH, M.D.

New York, N. Y.

Dear Editor:

The sensational publicity given the Kinsey Report is a social phenomenon of the first magnitude. It remains to be seen what the effect will be of such widespread dissemination of a set of figures and biases which in themselves are neither essentially new nor revolutionary.

It is true that Kinsey has established with a presumptive validity not hitherto claimed a set of figures on the incidence and frequency of certain sexual outlets in the male human. This attempt at taxonomic accuracy, however irrelevant from certain points of view, is nevertheless entirely legitimate on broad methodological

grounds. It is certainly Kinsey's privilege to limit his research in a complex behavioral field to the extraction from it of whatever is countable.

Had Kinsey stopped merely at the presentation of this data as such, and if the basic validity of his method of data collection were granted (Kinsey wisely allows a ten to fifteen per cent error), it might then have been solely for the statisticians to tell us how much richer the world would have been for his efforts. As it is, however, Kinsey, despite his disclaimers, has indulged in certain implicit and explicit assumptions about the significance of his data which cannot help but invite criticism from other quarters. I shall limit myself here to a few words on two of his major assumptions which somewhat conflict with psychiatric and psychoanalytic experience.

The first is that the frequency of orgasm is primarily a reflection of innate biological capacity and that the observed spread between individuals with consistently low frequencies and those with consistently high frequencies represents mainly a constitutional differential. This, of course, is a completely unwarranted assumption. There is nothing in Kinsey's method which enables him to distinguish between relative biological lack and socio-psychological inhibition or between superior drive endowment and compulsive sexual behavior.

The second of Kinsey's major assumptions, related to the first, is that the continuous (and "normal") nature of his frequency curves and the relatively high incidence of different forms of sexual outlet argue from the normality of practically any form of sexual behavior.

Such taxonomic detachment, while perhaps propagandistically useful in spearheading an attack on certain harsh legal attitudes, is nevertheless rather too broad to be of much help to the millions of individuals who would gladly exchange their often compulsory outlets or their positions on one or another of Kinsey's normal curves for outlets or positions less acutely painful. This pain, moreover, does not arise mostly, as Kinsey implies, from the individual's appreciation of his atypicality in relation to rigid legal and social scales, but mainly from the fact that sexual behavior, in whatever form, cannot (except for counting and classifying purposes) be isolated from other factors in a total life situation which may make for considerable suffering. And a suffering person is

likely to view his designation as normal on grounds of taxonomic objectivity as somewhat beside the point.

One can scarcely criticize Kinsey for not having investigated his subjects with methods of deep psychological analysis. It was not actually necessary for him to have done this in order to accomplish what he set out to do—count orgasms. But not having done this (and a few other things), it might have been much wiser had he refrained from taking a position one way or another on the question of good and bad, a fairly thorny issue which has bothered philosophers, physicians and countless John and Mary Does for a good many years.

JULE EISENBUD, M.D.

New York, N. Y.

Dear Editor:

I have seen a great many women in my professional work as a gynecologist. I have not only examined them—I have listened to them. When a physician is willing to listen, the patient will talk, and so will her husband.

I interview pre-maritals, and find almost without exception that they face marital relations with tension, anxiety and fear. The leaders in sex education reflect the same attitudes of “hush-hush” and are themselves bound by sex taboos. The leaders have been afraid to face the truth—and actually oppose any attempt to let in the light through scientific investigation. When I speak of the leaders, I should modify that to say organized leadership. Occasionally individuals had the courage to break through this traditional wall of misinformation and repression. The progress made is due to the efforts of such courageous individuals.

The public has articulated its need for help, and has demanded knowledge at a faster rate than our teachers were ready and able to give. It was the demand of Dr. Kinsey’s students that initiated and inspired his study. For centuries, statements were made about sex in authoritative voices for which there was no basis in fact. Dr. Kinsey undertook to ascertain through scientific investigation what were the facts.

The important attributes that Dr. Kinsey has brought to his study are: He is a trained scientist with courage and integrity. He has conducted a fact-finding survey of what people do sexually, with dispassionate objectivity and a sympathetic acceptance of people as

they are. His outstanding characteristic is his genius at establishing rapport with all groups and all individuals, from ministers to prostitutes.

Many have criticized Dr. Kinsey's book, emphasizing what it does not accomplish. The only fair evaluation is to compare it with what has been accomplished in the past. On that basis, his report is of monumental importance.

Our greatest need is the scientific study of human behavior, the most important and the most retarded of our sciences. Dr. Kinsey's report will compel us to a more realistic, a more scientific, and an honest approach to sex behavior. It will arouse educators to formulate an adequate program of sex education, which to date has been suppressed. His book has already broken down many harmful barriers and has let in air, light, and wholesome discussion. It will help to free us of many false concepts of what is normal and what is abnormal. I cannot completely accept his statements that there is no normal nor abnormal sex behavior—only variants. However, his study will widen our horizons greatly as to what is normal and acceptable.

The individual pattern of sex response is apparent very early in children. However, there can be radical changes effected due to environmental influences. There can also be a marked change with attainment of maturity.

The emotional relationship to sex behavior is of primary importance. There is also a glandular relationship to sex response.

Although we can learn a great deal about the physiology of sex relations from the animals—this relationship in the human is not a purely physical phenomenon in any but the lowest social and educational levels, nor do I think it is desirable that it be developed as a physical phenomenon.

Our sex education to date, has inhibited and blocked and repressed normal emotions. Wholesome sex education will help to increase, enrich, and deepen the satisfactions of human sex experience.

My suggestion is that there should be women interviewers added to Dr. Kinsey's staff. Regardless of how scientific an attitude, the interviewer is a human being, and the material must be received, recorded and interpreted through the medium of that personality. Although personality is more important than any other single qualification in such a study, it is inadequate to have interviewers of men and women carried on by men only.

There are many milestones in the history of man's evolutionary struggle toward freedom. Dr. Kinsey's work is one of these milestones. His honest scientific investigations will help through knowledge to free our American youth from fear of sex. (Part of the discussion of Dr. Kinsey's paper on "Comparison of Sexuality in Male and Female," read before the Association for the Advancement of Psychotherapy on April 9, 1948.)

SOPHIA J. KLEEGMAN, M.D.

New York, N. Y.

Kinsey's Report is both an unbiased account of what he observed and a body of facts from which far-reaching conclusions can be drawn.

Kinsey is not a reformer, but reforms in education and sexual hygiene may follow. His Report is shocking to some; it shows our generation in a cold light, unrelieved by any sentiment. Those who apply psychoanalytic methods are not surprised by his figures, for most of his findings tally with those made by Freud 50 years ago: that sexual activities do not begin in puberty, that human beings are basically bisexual, that masturbation is not a sign of degeneracy but a stage of normal psychosexual development; etc.

Paolo Mantegazza, August Forel, Richard W. Krafft-Ebing, Sigmund Freud, Magnus Hirschfeld, Ivan Bloch, Albert Moll, Havelock Ellis, and Wilhelm Stekel in their days were just as shocking as Kinsey. They met with contradiction and resentment. So did Sir Isaac Newton and Galileo. If monuments are erected to liberators, those who contribute towards liberation of mankind from fear, ignorance, prejudice and superstition in sexual matters also deserve monuments.

Many critics of Kinsey read into his report more than he intended to say. Kinsey "did not consider unconscious factors." Indeed, he didn't. He left this to the psychoanalysts. He "did not take into consideration the spiritual and ethical sides of sex." Indeed, he didn't. He left this to the religious and educational groups.

The resistance to Kinsey's rejection of the division into "normal" and "abnormal" in the face of the variations of sexual activity is impressing. If Freud is right in his theory that the human child is polymorphously-perverse and that in the process of maturation certain "perverse" patterns are abandoned in favor of an heterosexual adjustment, it may be conceded that what is "ab-

normal" in the individual's sexual behavior is simply a remainder of his infantile behavior pattern. Psychoanalysts may find in the patient homosexual behavior at the age of twelve and a perfect heterosexual adjustment at the age of twenty.

Are Kinsey's data accurate? The best way to disprove them would be by a counter-proof based on facts and not on speculation. One of the severest critics of Kinsey in this respect is—Kinsey. In the chapter "Validity of Data" Kinsey states:

"Throughout research of the sort involved here, one needs to be continuously conscious, . . . that it is impossible to get more than approximations of fact on the incidences and frequencies of various types of human sexual behavior. Memory cannot be wholly accepted as a source of information on what has actually happened in an individual's history. There is both deliberate and unconscious cover-up, especially of the more taboo items; and in dealing with people of diverse mental levels and educational backgrounds, there are differences in their ability to comprehend and to answer questions with any precision in any interview. . . ."

Kinsey's most surprising finding is the contrast between what the public thinks to be the normal behavior in the American male and what this behavior really is. The figures presented appear irrefutable, only the occasional generalizations and conclusions the author draws from his material may be subject to criticism. At any rate, the number of those interviewed, twelve thousand, is a more impressive figure than any figure psychoanalysis can supply.

Fear has been voiced that "indiscriminate knowledge" may be an "incentive to a lack of virtue." It was this fear that kept the facts about sex away from youth, a mistake that has been found to be prejudicial to education and the basis of many social and sexual maladjustments.

All in all, we may consider Kinsey's Report—with all its shortcomings—a turning point in the social history of our time. It is something we cannot silence or allow to drift by unheeded. Our criticism of the approach notwithstanding, it behooves us to assimilate whatever new knowledge the Report imparts. If, as is to be expected, the results regarding the female sex behavior will be equally revealing, we may see in Kinsey's work the impulse for a most profound change in the outlook upon the sexual behavior of our generation.

EMIL A. GUTHEIL, M.D.

New York, N. Y.

AUTOBIOGRAPHY (VI)*

WILHELM STEKEL, M.D.

PSYCHOSOMATIC DISORDERS. (A) BELLADONNA

At that time I had enough private patients, but I could not take all who asked my help because my spare time was reduced to a few hours. However, I accepted two patients, and was fortunate enough to cure them. One was a well-read, emotional and intelligent Hungarian woman who had tried different treatments before. The other was a seventeen-year-old baroness, who was suffering from nightmares and morbid fears. When walking in the street, she saw vast numbers of hallucinatory snakes, and had to jump over them. I discovered that her pupils were always enlarged and asked her about it. She admitted that she had put drops of an atropine solution into her eyes in order to give them an alluring expression. I knew by experience that belladonna was able to produce mental confusion. I remembered that among the first cases Freud had sent to me, there was a travelling salesman, who had fainted one day, and after ten minutes recovered, but had lost his memory. Freud sent me the case as one of suspected amnesia. I had heard that this man was troubled with stomach pains, that there was some suspicion of an ulcer, and that he was given belladonna to relieve the pains. One day I chanced to read in a medical paper that belladonna, under circumstances, is able to produce amnesia and even a transient mental confusion. I told the family of this man that psychoanalytic treatment would most probably not be necessary, and that the patient would be all right in a short time if he stopped using belladonna. His memory returned after two weeks. I had a similar success with the young baroness, but I had to go on with the analytical treatment because the nightmares and phobias did not cease.

* Cf. AMERICAN JOURNAL OF PSYCHOTHERAPY, April, July and October 1947, January and April 1948 issues.—We are publishing a series of excerpts from the manuscript of the famous pioneer of psychotherapy. Stekel's memoirs throw a light not only upon the personal background of an interesting man and a great physician, but also upon an early era of psychoanalysis in which the author played a prominent part.—*The Editor.*

(B) APHASIA

After my return from Hungary, a young officer entreated me to try my luck with his father. He knew a patient I had cured, was told that I had shown great patience, and strongly desired the cure of his father. The patient had been in a sanatorium for seven months following a stroke; he was too weak to walk; sitting in a wheel chair in the garden, or in his bed, he did not talk except the words "I can't." He suffered from a postapoplectic aphasia. Whatever you asked him, the only reaction was—"I can't." I explained to the son that I had no time to attend to such a case; but he was willing to compensate me for any loss of time.

I met an impressive old man with clear-cut features and a long white beard, in a nice sitting room giving on a garden. He answered my greetings by moving his head. I asked him if he was willing to be treated and got the usual reaction, "I can't." My experience with the schizophrenic sculptress (page 427) came into my mind, and I intended to use the same patience. Are there incurable cases? Let us try, anyhow. So I came every day, talked to the patient in a very kind manner. He looked at me with his big eyes as though he was interested. Except for the stereotyped answer I could not get any reaction. After two weeks of this hopeless procedure, I said to his son, "Let's finish this fruitless treatment. I am wasting my time and you your money." The son insisted that I should go on. He was convinced that his father's real trouble was psychogenic. He would take the responsibility and never blame me if the treatment should prove unsuccessful. I tried the same method I had used in the case of the sculptress. I asked my old patient to stand up and to make some steps in the room with my support. "I can't" was his answer. "But you must," I said to him with a more severe intonation of my voice. Slowly he stood up. He had an imposing figure, and was very tall, I hardly reached the level of his shoulders. At first he made only a few steps. Then we progressed more and more and finally we were able to walk into the garden of the sanatorium. The walk was extended to one hour, and he could find his balance without being supported. The miracle happened. He started to talk to me. I felt ashamed: The son, a layman, understood the case better than the psychoanalyst. I admired the touching love of the officer for his father.

After marked improvement had been achieved, the patient left

the sanatorium and was brought into an elegant apartment in the best hotel of Vienna. Visitors were coming and going, and could not understand the change. The old man walked up and down in front of his hotel for a few hours daily.

What was the cloven hoof behind the behavior of the son? My patient's affairs had been put under trusteeship; the son asked me to call in a well-known neuropsychiatrist for consultation and requested that we should explain in a certificate that the patient was now absolutely normal and able to come to legally valid decisions. The consultant arrived, examined the patient for more than an hour, and finally wrote a certificate to the effect that the invalid was now mentally recovered and in full control of his intellectual powers. Next day the officer explained his plans to me. In the last will of his very rich father he did not get his fair share. He knew my great influence upon his father. I was to suggest to the old gentleman that he should make a new will; he hoped his father would be grateful to the son who was instrumental in his recovery.

Now I found the solution of the riddle. It was not the touching love of a child, it was the cupidity of a would-be heir.

Other members of the family, favored by the last will, seemed to have guessed the intention of the son. They were afraid lest a new will be drawn and implored me to prevent such an unjustified step. They even wanted me to call in new authorities in order to prove that their father was not totally recovered. It was an ugly affair. I stopped the visits to my patient. By accident I got rid of the frequent visits of the son. Some time later he was transferred to front duty and was killed by shrapnel. My patient relapsed more and more into his former state and was finally taken back to the sanatorium. His speech again became restricted to the words "I can't." Later I understood those words: I was informed that his son had already asked him to make a new will, before he was afflicted by the stroke. Did the emotion induced by the request cause the stroke? I was told that after a while my patient could speak a few words, but he suffered a new stroke and died a few months later.

Was this an exceptional case or are there similar cases? There is only one rule: never lose patience! Some cases demand a great sacrifice of time, and reward the devotion of the physician by unexpected success. Many patients are cured by the fact that some one is interested in their case. Often it is not the method that is

responsible for the success, it is the satisfaction of the patient's desire for sympathy, of his longing for interest and companionship. This fact may explain the success of different schools of psychotherapy; it shows that success can never prove a method to be "right."

(c) STRABISMUS

I had the opportunity to treat a very interesting case of psychogenic strabismus. The patient was a lawyer who suffered from various neurotic symptoms. The outstanding one was his squint; his eyes wandered to right and left, and it was difficult for him to read. He had to study long briefs, to read books, etc., but in spite of his thick glasses he usually had to stop reading after a few minutes. In addition to this, he could not wear stiff collars; he invariably wore his shirt open at the throat, and had the peculiar tic of running his fingers round his collar as though he wanted to have more air for breathing. He was hard-up because he had married against the wish of his rich mother; she did not support him. He worked in a friend's office and earned a small salary; it was difficult for him to make ends meet.

He brought me a dream which he had submitted to different analysts in the hope of getting the right interpretation. The dream was as follows:

I was in a law-court accused of having killed my mother. The lawyer defended me by mentioning the fact that my mother was still alive. There was a long discussion as to whether it was possible for a dead person to be still alive. This discussion went on for hours, and I lost my patience. I looked at the court, at the judges, and said: You may kiss my a—, and left the court.

First the story and then my interpretation. Before his marriage, the patient was a gay Lothario, he passed like a butterfly from one flower to another. A nice, burly fellow, it was not difficult for him to make conquests. But one girl, the most attractive he had ever met, resisted for a long time. He wrote her many love letters and went so far as to promise her marriage. On these terms she gave herself to him before marriage. After a while she became pregnant, and he was compelled to marry her. The girl had kept his letters and he was at her mercy. It was during the war, and he had to go as an officer to France. He married her without his mother's knowledge and went to France. There he

stayed two years. Though he was a passionate man, he was absolutely continent; being extremely jealous, he was afraid of retaliation in kind. He came home to America the father of a nice little girl. Though he was very passionate, his marriage turned out to be a very unhappy one, because of his morbid jealousy. To walk in the street with his wife was an ordeal for both. She was not allowed to look to the right or to the left, and any man who greeted her was suspected of being a secret lover. The home turned into an inferno; quarrels and reproaches were followed by reconciliation, and—usually—by a passionate act of intercourse.

I asked the patient for the associations to the dream. The only association he was able to produce was the fact that the lawyer in the dream was the same who had once defended a man who had killed his wife with a hatchet. The man was later hanged for this crime.

I explained the dream to him as follows: "You haven't killed your mother, but you have killed your love for your mother, and her love for you. Your relationship with your mother is finished. Besides, you have criminal impulses to kill your wife, and to become reconciled with your mother, but you are afraid of being hanged for the crime. That is why you cannot wear a stiff collar, and the way you play with your collar comes from the feeling that you already have the rope around your neck."

"And what about my eye trouble?"

"There are various reasons for that. First, you are mentally blind to your problems. You do not want to see the truth; you do not want to know what is going on in your mind. The most important fact is that you have forbidden your wife to look to the right or to the left in the street. You want to apply the same idea to yourself. When walking in the street you are determined to look straight ahead, and not to see the nice girls passing right and left. (At that time it was the fashion to wear very short skirts, and girls freely exposed more or less pretty calves.) Against your conscious will your eyes are swerving to the right and to the left, so that you can—unwillingly—see the girls around you. This behavior is in keeping with your polygamous nature and your past as a Don Juan, while all the time you are pretending (to yourself) that you are looking straight ahead."

The effect of this interpretation was remarkable. The patient came to the next session wearing a stiff collar and without his thick

glasses. He was able to read as long as he wished to, and felt like a new-born man. (The consequence of this success was that a great many near-sighted and far-sighted people came to me during the next few weeks, believing that I am an exceptionally able ophthalmologist.)

(D) HYPOGLYCEMIA

In many diseases you will find a mixture of psychic and organic factors. One of my patients had a spell of depression. I visited him in his boarding house. He was so weak that he could not get up. He looked haggard, pale, and I was told that during the whole day he had taken no other food than a cup of tea without sugar. At this moment I suspected that he was suffering from hypoglycemia. I remembered that he was very fond of sweets, always had some chocolates in his pocket and used to eat them at intervals even during the analysis. I ordered a test to determine the amount of sugar in his blood. The sugar tolerance test confirmed my supposition. I asked the patient to drink a strong solution of sugar, in a short time he was a different being: his cheeks grew rosy, his pulse calmed down, he felt strong again and left the bed a new man.

(E) AEROPHAGIA

I have very often observed that some patients use tricks to increase their psychic troubles. A man who suffered from anxiety states when he had to cross the streets, sighed, breathed deeply and frequently, and swallowed air. The distended stomach pressed on the diaphragm, the diaphragm pressed on the heart; the attacks of palpitation were partly due to excitement, partly to aerophagia. Here we have a vicious circle, in which one symptom increases the other.

(F) THE QUINCKE EDEMA

What is science? It is the recognition of a new truth, not the defense of an ancient dogma. In this connection, let me recount a most instructive episode.

I once treated a case of Quinke's disease (angio-neurotic edema). The patient was a lady, aged forty, who suffered at intervals from extremely disfiguring attacks of edematous urticaria of the face and hands. For seven years she had been ineffectually treated at various clinics. One of her doctors recognized that the malady was psychogenic, and for that reason sent her to me.

I handed her over to my Dutch pupil Lingbeck, who discovered the following facts: The patient, a married woman with a grown-up daughter, did not secure adequate sexual gratification in the intercourse with her husband, but did so in association with a lover. The attacks of angio-neurotic edema always came on after a visit to the lover, and were obviously a self-inflicted punishment for infidelity. (Fear lest the daughter might learn of the mother's misconduct was also a part-cause.) We advised her to discontinue the extramarital relations. She did so, and the attacks of Quinke's disease ceased.

At my insistence, Dr. Lingbeck brought the case to the notice of the Medical Society. Its interest lay in the fact that it invalidated the hitherto existing opinion that an adequate sexual gratification is a cure for neurotic disorders. Here the neurotic symptoms followed adequate sexual gratification, but ceased when the gratification was renounced. When this had been explained, one of the doctors voiced his objection: the case presentation was not suitable for the Medical Society. The results had been due to chance, and had nothing to do with science. This declaration was vociferously applauded.

I intervened, and said that time would show whether Lingbeck's inference and mine had or had not been "scientific."

The patient was seated in the ante-room listening to the rather heated discussion. Her natural reaction was: "These experts do not believe that my malady was caused by my love affair. Why, then, should I deprive myself?" That very day she phoned to her lover; they made an appointment, and she enjoyed herself in the old way. But within a few hours she had a distressing attack of Quinke edema, and came ruefully to consult Lingbeck. He and I were able to convince her that the illness was a conscience reaction. Now she permanently broke off the liaison, and was permanently cured. As to the last statement, I was reassured when I again saw her several years afterwards.

(G) EPILEPSY

Meanwhile I had made a discovery of great importance. I treated cases of epilepsy, was often surprisingly successful, and I learned by experience that many cases of so-called epilepsy were mentally conditioned, or were complicated by a psychic superstructure. In many cases you may improve the condition of

patients, in some you may cure them completely. My desire was to drag the patient out of his isolation and idleness, to induce him to work, and even if he continued to have fits, they were, in any case, diminished in number: I was able to make him a useful member of society.

After the publication of my paper on epilepsy, I was sent an issue of a journal, *Der Wendepunkt* ("The Turning Point") edited by the Swiss physician, Dr. Bircher-Benner, a pioneer in dietetics. The leading article in this issue called "A Great Triumph in Science" gave a summary of my research on epilepsy. I was pleased because it was the only affirmative voice among views that were otherwise invariably unfavorable. Clinicians treated me as a "fantastic mind," and were far from acknowledging that I worked hard to bring light into a dark problem of medicine. Like a lioness defending her cub, so the psychiatrists defended epilepsy as an incurable organic disease.

(Bircher-Benner was enthusiastic about the fact that in my psychic treatment the use of narcotics was debarred. I found that they reduce the activity of the patient and bring about regression into day-dreaming. The epileptic finally becomes a drug-addict.)

I once treated a patient suffering from what was described as "genuine epilepsy." Surgical operation had been fruitlessly tried, but psychotherapy was successful. Did this "prove" anything? No, for doctors insisted that if the patient was cured, the diagnosis of "genuine epilepsy" must have been wrong. My view that some cases of "genuine epilepsy" are psychogenic was dismissed as "unscientific."

WAR PSYCHIATRY

During the first World War I was working at the neuro-psychiatric section of a large war hospital in Vienna. It was built for three thousand patients. My department had two barracks with a hundred and forty patients all told; besides this, I was busy with consultations from other departments. By a strange coincidence, Alfred Adler was my predecessor. He had been transferred to a provincial town, although he had done excellent work here. His examinations were profound, his histories of the diseases were blameless, he was a model physician.

I did not know that I obtained this responsible position only on trial. The first cases with my findings and diagnoses were sent,

without my knowledge, to be looked over by some prominent men. I had good luck. I was very cautious. Every new patient had to undergo a thorough examination. My first three cases were very interesting, I had to decide between a serious organic disease and malingering; my diagnoses were confirmed; in a short time I enjoyed the confidence of all my colleagues and later I was given the right of independent decision; my decisions were accepted without further supervision.

I sympathized with the poor soldiers, and tried to protect them as much as possible. This became known among them and they felt confident of my good will. Even malingerers confessed. I despised those physicians who were slaves of the war-mongers and forced half-recovered soldiers to go back to the trenches. I have seen terrible examples of the work of these executioners; convalescents wounded in the war, still in pain, with their wounds not healed, were sent back to their regiments. In many hospitals they were tortured by a faradic brush, so that they preferred the terrors of war to the terrors of the hospital. Every week the chief of the hospital, a major, a former dentist, came into the ward and shouted "We must evacuate! Send fifty percent of the patients away! A new transport is coming!" At the same time disgraceful favoritism existed in the hospital. The chief, the head-nurse, and two sergeants formed a corrupt clique. Rich patients loafed around for months and months. In order to keep them in the hospital, they were classified as suffering from non-existent diseases. Often I had to fight to protect the soldiers against undue cruelty. The whole corruption was covered with a superficial varnish of hypocritical religion: every Sunday all physicians had to go to mass. It was the wish of the almighty pious head-nurse. In the first row sat the Major in his best attire, puffed up with self-righteousness.

Some cases I would have liked to analyze. There were so many shell-shocked persons, hysterics, tremblers, dancers, the paralyzed, those affected with dumbness, etc. It was as if a sorcerer had transferred me back to the time when I studied with Krafft-Ebing. I am convinced that all cases of shell-shock and war hysteria are caused by a psychic conflict; on the one side it is fear of death and disablement, on the other the duty towards the country.

In our hospital, because of lack of time, mental treatment other than hypnosis was impossible. So I started to hypnotize my patients and achieved good results. In my barracks an atmosphere

gradually developed that was favorable to hypnosis. These simple people believed I was working with magic. As is known, it is difficult to hypnotize individual neurotics in the office, but it is easy to hypnotize a group of people simultaneously. One is impressed by the example of the other. Therefore, men working with hypnosis often have several particularly submissive patients on whom they perform their miracles before starting with the new patients. Public hypnotizers generally have one or two bogus "mediums" (assistants), to implant the suggestion upon others.

I was able to hypnotize most of my patients. Sometimes when I was making my rounds I would achieve a general sedative effect by commanding, "Sleep one hour!" while pointing with my index finger at the individual patient, and one after the other would fall asleep and remain quiet for the required time. Of great help was the fact that I was considered by my patients their friend and protector. They were never sent back into the trenches and in most cases they were qualified for light service in the "hinterland." During my therapy I often had an audience of other physicians, and the head-nurse never missed my hypnotic sessions.

Among my patients there was a man who had lost his speech following a persistent artillery barrage. I promised to cure him in a few minutes. All the doctors of the hospital together with the chief surgeon and the head-nurse gathered to witness this demonstration. I used a different method—fascination. The patient, a simple Hungarian peasant (I could not communicate with him as I do not speak Hungarian), was sitting opposite me in a chair. I looked persistently into his eyes for two minutes and then I intoned "A-a-a." Like an automaton he repeated the "A." Then I used other vowels, progressed to syllables, and finally he repeated a few Hungarian words I had learned at the hospital. Finally the expected miracle occurred: he was cured. A stream of tears broke from his eyes. Was he a malingerer? And did he feel sorry that I had overpowered him? I do not know. I kept him in the hospital for a few weeks and then sent him back to be assigned to light duty.

A CASE OF SCHIZOPHRENIA

A short time before the war began, I was treating a young girl, a mental case. The day I was called to see her, she had smashed all the furniture in her room. Her father told me the story of her

disease. In a normal state she had made a trip to Italy. She came back with a slight depression, and in a short time she was so completely unbalanced that her father asked the opinion of the famous psychiatrist, Wagner von Jauregg. He took her into his clinic, but there she became progressively worse. Finally Wagner-Jauregg diagnosed the case as schizophrenia and declared the patient incurable.

I found this beautiful girl, who looked like a doll, in her room, in a negativistic state. She did not talk, did not change her dresses and left her room only for her necessities. I spoke in a kind manner to her. She did not answer. But I did not lose patience, and came every day, trying to get a contact with her—at first, without success. She was a sculptress and some of her work was on the table, so I spoke about her drawings, sometimes holding her hand, which she permitted without protest. After a week she spoke the first words to her parents. "Why didn't you bring this man sooner?" Nothing else. I knew that I had won the battle. I continued my visits, but she remained a mute figure. For three months she had not left her apartment. After I had seen her for two weeks, I felt I must break her resistance and followed my intuition; I said to her, "Elizabeth, please put on your coat and let's go for a walk." She looked at me in astonishment, but like an automaton, went to her wardrobe, put on a coat, looked in the mirror for the first time, combed her hair, and went out with me. She led me to the studio she shared with another sculptor, and there she let me see her own work. It was hyper-modern, but it betrayed great talent. I spoke about her sculptures and—surprisingly—she responded; thus we got into a fairly normal conversation.

The resistance was broken, she told me her story and her dreams, dreams in which the Holy Virgin and other religious symbols appeared very often, together with symbols of guilt, as though she were soiled. In many dreams she tried to wash herself; once *she met Lady Macbeth, who said to her, "All the perfumes of Arabia will not sweeten this little hand!"* I asked her why she felt so guilty and she finally told me the story of her trip to Italy. She had pretended that she had made this journey in order to see the beautiful places and famous pictures, in the company of a friend, but on the trip she met the sculptor with whom she shared the studio; there she became his mistress. Unfortunately, she had no

adequate sexual gratification in intercourse that could have served as a compensation for the sacrifice of her virginity.

My conclusion was that she was frigid as a consequence of her religious upbringing. I had seen other patients, girls and women, who were frigid during their relations before marriage, but became normal after marrying the same man, because the inhibitions of conscience were removed by the legalization of the relationship. I thought marriage with the sculptor would cure this lady. (Very often it is the other way around: a woman who has been frigid in marriage becomes passionate in an illicit union.) I invited the sculptor to see me, explained to him that he was morally responsible for Elizabeth's disease, and expressed the idea that perhaps marriage would effect a cure. He seemed willing enough. I hoped that my information concerning her lover's willingness to marry her would have a beneficial influence on my patient's frigidity. But to my astonishment, she reacted in a very different way. "I shall never marry that man," she said. "I don't want to see him again."

The case proved more complicated than I thought. The patient had a very attractive sister, tall and fairhaired. This sister had first conceived the idea of calling me in, and came frequently to the hospital to talk about Elizabeth, who was the pride of the family. I was very fond of the sister and at one time even believed I was in love with her. I wrote a poem (published in my book, *The Wise and the Fool*):¹

I did not know there was a rivalry between the two sisters as a consequence of a homosexual fixation. (I call that the *tertium quid* of love.) The sculptor had originally been in love with the sister, and Elizabeth "annexed him" to outrival her sister. Had she noticed that I too was interested in her sister? Did she play the same trick on me? Anyway, it was clear that the sister was interested in me, and that our unexpressed affection was mutual.

I did not press further the desirability of marriage between my patient and the sculptor, and he, on his part, was glad to be relieved from the obligation. Meanwhile Elizabeth improved; she gradually became more or less normal and she wrote the story of her "miraculous cure" in the rich style found only in great poets. But there were still various symptoms left. She would go out only with me

¹ *Der Weise und der Tor*, published by Paul Knepler, Vienna, 1918.

"Fools they that die for some dead past, in vain!
All he once lost, the Wise Man wins again. . . ."

or with her father, never alone; she would quarrel with the members of her family; and she had no inclination to resume her former work, her sculpture.

ON THE BICYCLE THROUGH THE ALPS

It was the first year of the war. I had been given a fortnight's leave, after hard work in the hospital. The work there was made even more unbearable because we had to treat so many maimed and mutilated soldiers. Every day a transport came in was horrible. The stench of the bodies was terrible. People who had not washed for months, who had wounds oozing pus, and frames shockingly lacerated. It is still a most dreadful recollection. I could not then foresee that after such an experience I was to endure a second "great war." All these men were innocent victims of war; they hardly knew what they were fighting for. I asked many soldiers if they knew why there was a war. (My knowledge of different languages was a great help to me.) Most of these wounded men did not know the answer. Many maintained that the Czar wanted to take a part of Austria-Hungary from our Emperor. Later I read the German translation of a Polish novel by Wendel, *The Salt of the Earth*. Everybody should read this book. The chief figure in it was a poor Polish peasant, a hand at a little railway station who had to join the army and did not understand why he had to fight or what was going on around him.

I had decided to use my leave for the fulfillment of a long standing desire. I would make a trip with my son Eric on bicycles through the Alps. The first stopping place was the cottage of my patient Elizabeth. My reception was enthusiastic. I saw that Elizabeth had made considerable progress. She was quite normal, except that she had no inclination for work, was easily depressed, and quarrelled continuously with her sister.

My cycling tour through the Alps was an enduring joy. Every hour brought us new landscapes, new quaint and quiet places, peaceful little inns; we climbed the mountains and swam in rivers and lakes. There were very few cars on the roads; any necessary repairs to our bicycles could always be made at the nearest repair shop. We did not feel tired, even after a whole day's trip. It was like a manic excitement, and I thought how disappointing sobriety would be after intoxication. It was the warning voice of doubt; but these misgivings were of short duration, and were easily dis-

pelled by the enchantment of the trip. My son Eric has often told me that this fortnight was the most memorable one in his life, and that he doubts if he will ever again have such an enjoyable experience.

THE VITAMIN OF LOVE

In this phase of my life a second example taught me how love influences creative art. I was called in to see a woman-artist who wished to know me personally after she had read some of my books. Her name was familiar to me because I had attended an exhibition of her pictures, which were a sensation at the time. We became friends and she confided her story to me. She said that one day she discovered that her husband was having relations with her servant. She threw a cup of coffee at him and her relations with him ended then and there. Her husband's brother, a young officer, sympathized with her, consoled her, and finally they became attracted to each other. Whereas prior to the incident with her husband she had earned a mediocre livelihood by making copies of paintings and by designing post cards, under the influence of the young officer she commenced to work on her own creations, and soon became famous. However, she couldn't work unless her brother-in-law was in the room. While she was painting, he would invariably read to her, poems or other romantic literature, but she had to hear his voice all the time she was working. It was as if his voice was whispering, "I am here! I am here! And you know I love you!" Even when she was painting a portrait, he was there, reading. Her creations were a compensation for her own lack of beauty in face and form. Her desire for beauty found a medium for expression in her creations. In the beginning of the war she followed her lover to various places and produced some vivid war pictures. But the war separated them. He found another woman—she was forsaken. Her power for creative work dwindled, and she went back to doing "copy" work. Her brush had been made effective only by love. Through gratified love she rose to be an artist, able to overcome her sense of inferiority. Deprived of love, she again became a mere copyist, an undesirable elderly woman.

DISORDERS OF INSTINCT AND EMOTION

My real satisfaction was my work. I had just completed my

volume on *Masturbation and Homosexuality*.² Following the great success of *Anxiety States*, my publisher was anxious to have this new book published, but he doubted if it would be a good seller during the war. At first he hoped, as everyone else, that the war would be over within a few weeks. The time went by, weeks, months, and years; finally he plucked up courage and my manuscript was sent to the printers. Then he became troubled about the size of the volume. He asked me to publish only the two parts, "Masturbation" and "Homosexuality" as a separate volume. They were already in type, and by adding some additional chapters to the beginning and to the end, I was able to arrange it as a single volume. The book appeared during the war as the second volume of my series of ten volumes on *Disorders of Instinct and Emotion*. The first edition of *Anxiety States* was now called "Vol. I" of this series. I am grateful to the publisher for having stopped the printing of the whole work at this juncture. Thus I had time to enlarge the different parts, to collect new observations and to deepen my conclusions. I also obtained enough material for the next (third) volume, *Frigidity in Women*.³ One day I gave a popular lecture on this subject. The auditorium was filled to capacity. As a consequence I obtained rich material for further study—many frigid women, both poor and paying patients. Freud did not reckon with my ability to maintain a good practice without his help. However, through my articles in newspapers, my lectures and, finally, through my books, I was able to attract a large number of patients—except during the first weeks of the war—and it was not even necessary to fall back upon my savings. I never permitted myself to be coerced by anyone. Freedom of action has always been the guiding star of my career. After I broke with Freud, my journalistic work was of great help. Freudians later used this fact to stigmatize me and to deny my scientific qualification calling me a mere journalist. Their humiliating reviews did not trouble me, nor was I disturbed by their often venomous animosity. The new book on *Masturbation and Homosexuality* became a great success despite the war. In a short time I had to publish a second edition. Mean-

² The part on Homosexuality appeared in English in two volumes, *The Homosexual Neurosis* and *Bi-Sexual Love* (translated by J. van Teslaar), Emerson Books Inc., New York, 1922, 1936 and 1946.—*The Editor*.

³ The English translation by J. S. van Teslaar appeared in 1926, Liveright Publishing Corp., New York.—*The Editor*.

while, *Nervous Anxiety* went into a third edition, which was published without Freud's preface.

I enjoyed my work at the hospital. One day I was summoned by the superintendent of the hospital to his office. He asked me if I would like to become the head of a large neurological station. The thought flashed through my mind: Was I fit for this work? I accepted but asked for a week's release from duty. This free week I employed, day and night, to prepare myself for my new position. I feel no constraint in confessing that at that time I had forgotten a great deal of anatomy, so important in the treatment of war injuries, and even of neurology. I bought two textbooks and read up on the topics in question with the zeal and concentration of a freshman. My experience at Krafft-Ebing's clinic was of great help to me. It was just a matter of refreshing my former knowledge. I also bought various instructive diagrams, and when my assignment arrived, I was sufficiently prepared to meet it.

THE DINNER SPEECH

Before leaving the hospital, I attended a dinner in honor of our chief. About twenty physicians from the hospital, together with the guests of honor were gathered at the restaurant, and among them was a very famous man. The dinner was scheduled for eight o'clock. It was eight-thirty when someone timidly inquired if the chief had been informed about this dinner. To the great dismay of all present we learned that he had not been invited. Two men went to his home, but he was not there, and no one knew where he could be found. They returned "empty-handed." We decided to go ahead with the dinner and thus save an extremely embarrassing situation. On this occasion I delivered a long speech, perhaps the best I have ever delivered. "Through this mishap," I said, "we are inaugurating a new type of testimonial dinner. These dinners should be arranged without the presence of the guest of honor. It is a splendid opportunity! Heretofore we have always been obliged to praise and flatter the honored guest; under the new system we are free to criticize him and to expose his weak spots." I continued in this vein, and finally I asked all present to drink to the health of our beloved chief, absent though he be in body and spirit. A roar of laughter followed, and the enjoyable evening lasted until well after midnight. Our chief stated later that it was the best testimonial speech he had ever *heard of*.

Years ago I had a similar opportunity to turn general embarrassment into unrestrained merriment. It was during a trip to Norway in an atmosphere of strict formality on an Austrian luxury steamer. On the eighteenth of August, the birthday of our Emperor, the captain arranged a solemn banquet at which he had to propose a toast. The captain was a fervid Italian nationalist, anything but an Austrian patriot. Nevertheless, he was determined to go through with the ceremony and, however unwillingly, he began as follows: "Though we are here in the far north—though we are here in the north—the far north—" He broke down and could not proceed. Picking up his prepared speech, whose transcript lay on the table, he tried in vain to continue. His id was in revolt against the undesired obligation, so he cursed and fumed and wound up by saving "Three cheers for Emperor Franz Josef." Some not very enthusiastic cheers followed and then a distressing silence. Everybody was in a bad humor, the captain embarrassed. I rose and made an impromptu speech.

"Dear Captain, ladies and gentlemen: What is the duty of a captain? To navigate his ship. We do not care a hang that our good captain here has been stuck in his speech as long as his ship does not get stuck. Let's drink to the health of our efficient captain."

The atmosphere cleared—everyone was relaxed. The captain embraced and kissed me, and regaled us all with champagne.

It was one of "life's little ironies" that that very night our ship did run aground, and were it not for the fact that we hit upon a sandbank, we would have lost our lives. That same night a Norwegian steamer struck a rock in a fjord, causing the engine to explode and all aboard were killed.

A GREAT PASSION

At this time I went through a great passion of my life. Among my patients I was especially interested in a German lady, an aristocrat, emaciated like a skeleton because any dish she ate gave rise to severe pains in her stomach. One of her main troubles was her difficulty in reading. After a few minutes of reading the letters swam before her eyes. The deeper motive of her disease was very interesting, but discretion forbids me to go into these details. This lady was near to forty, and the mother of four children. Her treatment made only a little progress, the season in Ischl—where I was

treating her—was finished and I had to go home. Her companion told me, at my last visit: "You have had bad luck with my mistress. She confided to me that she feels very happy that she doesn't have to go on with this unbearable method."

I felt perhaps a little more hurt than in other cases, but there was nothing I could do about it. I returned to Vienna; two or three weeks passed by, I heard no word from her. Then she came and—was a different being. She resumed treatment and developed a strong transference. I yielded to such an exaggerate counter-transference that I lost my poise.

The patient improved every day, put on weight, could read without difficulty, but I, her physician, was in the throes of a veritable love fever. I had never been so unreasonable before. I was carried away like an adolescent. She was a Nordic type, fair-haired, tall, slim; the very opposite of my mother who was dark short and plump. (Our choice of love partners is determined by our infantile ideals. Was Freud right when he suggested I had a mother fixation? We choose our ideal either by identification or by differentiation from our infantile fixation. "Les extremes se touchent.") I was always longing for a fair-haired girl, and I mostly fell for the opposite. This time it appeared to be the realization of my ideal. Her voice was so sweet that it was a great pleasure for me to listen to her.

We were both unhappy in our marriages and were firm in our determination to get divorced from our then partners and to marry each other. My poetic faculty came to life once more. Every day I brought her a new poem. (Some of these poems were later published in my book, *The Wise and the Fool*.) Neither of us concealed our intention to marry, and we wrote about these important decisions, I to my wife, she to her husband. Disagreeable letters were exchanged, but we remained resolute. Love was stronger than reason.

The war broke out and she had to go home. At first we exchanged daily letters, then the correspondence ceased. One day I received a letter from a friend of hers with the following story. Her husband, an officer of high rank, was wounded during the first weeks of the war; his life hung in the balance. She had the idea that if she could give him unexpected joy he would recover. She promised him to give up our relationship and to stay with him forever. He recovered and she kept her word.

Our love was so strong that we had the intention of dying together if we could not marry. Later I realized that I would have been very unhappy with her; our backgrounds were different, and discords would have emerged shortly after our marriage.

I tried to forget her. I devoted all my time to the wounded and sick soldiers. Every fourth day I was on duty for twenty-four hours. But alas, I could not forget. I was still like a man enchanted, walking about in a dream. I read her letters over and over again. Life seemed empty and worthless. In my free time I walked for hours and hours recalling alluring pictures of the past, and looking into a dark future. I had no patience for analysis—and I had no patients anyway. My salary as a hospital physician was too small to cover my expenses. I employed my journalistic talent again and wrote items for newspapers. They were later collected and published as a book under the title *Psyche and War*. I was tortured by desperation, yearning, self-reproaches, and a feeling of futility. After the last emotional upheaval, the lull that ensued was unbearable. La Rochefoucauld writes in his aphorisms: "You are never so ready to enter a new love as when you have finished an old one." He is right. Like a madman I was looking for a substitute. Each slim, blonde girl or woman who showed a real or fancied resemblance to my inamorata attracted me for a moment, but disappointment followed soon and I would turn away from her.

POST-WAR VIENNA

The atmosphere of war was favorable for cheap conquests. In the hospital there were many girls and women from good families working as nurses. The milieu impressed them so tremendously, that their sympathy with the sick, and their enthusiasm for the great events which were happening in the world ultimately turned into simple sexuality. Many of these girls gave themselves to the service men or to the physicians without particular scruples and without pretending to be in love. Some of them were daughters of physicians, of men in high positions, even aristocrats; the fact that they were permanently working with men, and that war brought the theme of death into the foreground of their consciousness, must have produced this effect.

Alas, the war lasted years; my son, a young and gifted musician, had to join the army and after a short training period was sent to the front lines.

The last year of the war was horrible. I had no cause to complain about lack of food. I was able to obtain enough meat and bread at the hospital. There were smugglers, black marketeers who could furnish almost everything, but at fantastic prices. The cost of living increased enormously from day to day and the population suffered greatly. More bread was needed; my wife went to one of those private bargainers, and in exchange for a part of the layette of one of our children, received some provisions. It was an incongruous sight later to see the child of these otherwise poor people clad in laces and silks. The conditions affected also the morals of the individual. If anyone made a new acquaintance he was involuntarily haunted by the thought, "What can I get from this man? What can I use him for?"

I had a patient who boasted of his erotic experiences during the war. He used his great store of sugar and flour to make easy conquests among women. He would accost a woman on the Ringstrasse, saying, "You look very pale! What do you need? Sugar? Flour? Meat? I can provide you with everything you need." So for two pounds of sugar he obtained what he wanted.

I liked my work at the hospital. The gossip of my personal opponents among the Freudians was perhaps the reason why my colleagues at the hospital at first doubted my scientific qualifications, but in a short time they changed their mind, and we became good friends. On duty days, when not disturbed by visitors, I used my free time for correcting proofs, for writing and for study. Oh these visitors! They became a terrible nuisance. All my "flames," all my acquaintances (and I had so many) found out that I was on duty every fourth day. They seized the chance for a visit to my private room. They disturbed me in my work, and while I was yearning for true love, I was not always able to free myself from passing flirtations.

At last I met a charming young woman. She later became my fate and my fulfillment—my present wife. I decided to break off all liaisons except the one with a woman who appealed to me mentally—my future wife. (Mother of two children, she was unhappily married and was about to be divorced.)

I had only one thought, to marry my loved one as quickly as possible. She became my best collaborator. She corrected my proof-sheets, gave me many ideas for my new book, *Frigidity in*

Women, and developed a great analytic ability. I used her as an assistant in psychoanalysis, and she was very successful. Was it inherent in her, or did she learn by constant contact with me? At any rate, I can say without bias that her skill and intuition are outstanding.

A short time later I had a second assistant, Emil A. Gutheil. He was then a student of medicine. He wrote me a letter asking for my opinion in one of his dream interpretations. I noticed that he had great talent for psychotherapy, invited him to call on me, and gradually he became my collaborator. Though he was still a student, of very limited means, I referred to him enough cases so that he was able to earn his living. He became one of my best pupils. (He is now practicing psychoanalysis in New York.) I was much impressed by the integrity of his character and observed that he never flattered me like other sycophants. He was very efficient in his work and always loyal and faithful.

Without the help of my present wife I could not have come through the horrors of the war and post-war period. She had a warm and sympathetic understanding of mankind and shared my ideas of humanity. I gave her the pet-name of "Gulf" from the warm gulf-stream that flows through the ocean from the Gulf of Mexico to Iceland. Every Sunday we went for a hike through the hills around Vienna. We were both very happy; we liked to discuss and exchange ideas. At first I appreciated her naivete and kindness; later I was surprised to find that she was a person of high intellectual attainments, and that her interests and ideals corresponded with my own.

(To Be Continued)

THE PROBLEM OF THE PSYCHOSOMATIC PATIENT

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The present trend toward psychosomatic medicine presents us with the necessity, and even the urgency, to adopt measures for handling the patient from the psychological standpoint as well as from the somatic. In order to do justice to this concept of therapy, we must formulate a practical program of action designed not only to cope with the psychological aspect of a disease as it confronts us *after* the patient has consulted us; but also offer to the patient well-considered suggestions and prophylactic advice, so that he may mobilize, from within himself, the power to handle intelligently a disease or a problem, whenever they should strike him.

As a rule, this therapeutic task does not require a prolonged analysis but rather the encouragement of adequate responses to ordinary and extraordinary life situations. Especially does this apply to individuals who are troubled with so-called functional diseases and who show during the interview a tendency to neurotic behavior or response.

In general it would seem that a person who presents a vague history of illness, with bizarre complaints, exaggerated emphasis upon minor symptoms, or the opposite, unduly reduced reactions to painful or annoying stimuli, needs such attention most. It has been stated repeatedly that no office visit can be considered complete unless some help toward psychological adjustment has been offered by the physician. Such help may consist of a friendly and sincere understanding shown by an appropriate remark, or by a brief or more lengthy discussion of disturbing circumstances.

Of course, one may counter the last statement by the stereotyped objection that the busy physician has no time for this sort of approach and that his attention is consumed by the physically palpable, visible, audible, and the chemically (or otherwise) discernible material. There is hardly time enough to keep up with these, let alone to go into the details of mental quirks which are brought about by adverse home situations, social maladjustments and early psychological traumata.

What can be the answer to such a compelling critique? There are many—but two may suffice at this point.

(1) Obviously organic causation of disease is the rock bottom upon which the psychological structure rests; it must be looked for by all available methods and, if discovered, must be adequately dealt with. In a great number of instances this alone may result in cure; but all too often such an approach allays only a part of the patient's complaints and, as any experienced practitioner knows, even in some of these organic cases only limited effects are produced, because the patient's basic mental outlook is not sufficiently taken into account. Now, if even in the obviously organic cases only partial results are obtained, what can be expected in the overwhelming majority of our patients where all our diagnostic means may not reveal any physical etiology? In these cases we are compelled to fortify our patient psychologically, until he either cures himself or until the diagnosis of an organic disease can be established. Even after the organic disturbance has been corrected, the patient is not "out of the woods" as far as living in inner comfort is concerned. It is, therefore, imperative that we alter our accustomed views somewhat and place less emphasis upon technical and mechanical information and interpretation (admittedly crude in many instances), but more upon educating the patient in the art of living in peace with himself. It is true that in an industrialized and standardized nation like ours, mechanical measures are enticing and appealing; but the patient needs more than these.

(2) Much of the time of the average physician is occupied by seeing functionally diseased patients. That is in the main what makes him a "busy" physician. If he is not sympathetic to the idea that these people are at least as worthy of help as those in whom he can diagnose organic disease, he will either waste his time with useless examinations, and with prescribing and administering useless medication, or he will send the patient away in a frustrated state of mind. As a specialist and internist, this writer can testify from many years of experience to the fact that, in the long run, visits are less time-consuming and more constructive when a more psychological technique is employed in dealing with patients who present psychosomatic conditions. Useful somatic and laboratory procedures must never be overlooked, but neither must psychological elements be slighted. They are always to be looked for and dealt with.

Just as adequate nursing is a *sine qua non* to quick recovery

of a gravely ill person, so the establishment of an adequate response to the home environment and the social environment is necessary for recovery. This requires an intelligent appraisal on the part of the therapist of the basic elements which produce the disturbing situation within and without the patient. We must also make an estimate on the patient's recuperative capacity and his desire to get well based on his past performance. By such an approach the course of many diseases will be shortened and the physician will be relieved of much unnecessary work.

The great problem confronting us now is how to induce and instruct the average physician to think and act in terms of teaching patients the art of thinking constructively and reacting wholesomely. This writer feels incapable of furnishing the answer to this question. It is his hope, however, that in this JOURNAL thoughts, plans and suggestions will be offered on how to launch such a program and instill life into it. Psychiatrists alone cannot and should not assume the task of handling the psychological aspect of somatic disease. Every physician must participate. As Wearn¹ stated in a recent article, "The very magnitude of the problem of functional disease, involving as it does millions of patients, demands methods of diagnosis and treatment which are practical and readily available to all patients."

¹ J. T. Wearn, The Challenge of Functional Disease, J. A. M. A., 134, August 30, 1947, p. 1937-1940.

CASE REPORTS

BACKACHE AS A PSYCHOSOMATIC PROBLEM*

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Backache is an extremely common symptom for which the patient frequently seeks medical or surgical relief. In recent years the psychic significance of some forms of backache has been recognized. The association of backache and inner conflicts is illustrated by the case of a patient who applied for therapy at the New York Consultation Center after having exhausted the traditional medical therapies for this condition.

The patient, a man of forty, was referred by an arthritis specialist because of pain in the lower back, radiating down the thighs and legs. His pain had resisted various types of medical treatment which had extended over the period of his illness. He had had many workups in vainless effort to discover an organic cause. However, findings were completely negative.

The onset of his symptoms had occurred seven years previously. The content of his first interview was concerned with details of his discomfort, suffering and disabilities. The patient revealed that his backache had developed suddenly about three months after the death of his first wife from cancer. He was, however, unable to associate this with his wife's death.

At the second interview, the patient disturbingly confided the presence of other problems besides his backache, which involved his sexual life. His primary concern, he insisted, was with impotence which he believed to be the consequence of and perhaps even punishment for "excessive" masturbation. His impotence, he revealed, was even more disturbing to him than his backache. It had made for much unhappiness in his marriage. His first attempt at coitus had been in marriage which had occurred when he was twenty years of age. At that time he had a premature ejaculation. Subsequent to this on all other occasions he had a poor erection or he was completely impotent. As a consequence, his sexual life was disappointing to both himself and his wife.

He might have had a chance to make a better sexual adjustment if his wife had been a different kind of person. On the one hand, she was a strong, motherly woman who encouraged his submissive, dependent tendencies; on the other hand, she was frigid, complained of vaginal pain and

* Presented at a Staff Conference of the New York Consultation Center.

discouraged his sexual advances, reinforcing his misgivings that intercourse was an anti-social act. This combination, for one of his character structure, was doubly frustrating.

The marriage lasted thirteen years. He felt guilt toward his wife, believing, as he did, that their sexual difficulties contributed to her nervousness, and even to the development of cancer. The cancer was first manifest in her intestinal tract, then in her breast which was removed; finally she underwent a hysterectomy.

During the last three years of her life, emotionally painful as they were to him, he had an added burden of guilt since he was driven to extra-marital attempts, though these also were abortive.

In spite of his lack of sexual potency he was unable to resist getting married a second time, hoping that his remarriage would restore his sexual powers. He was, however, disappointed in this. He credited his inferiority feelings to his impotency. He felt inadequate in all areas including his trade which was that of a printer. From time to time he had symptoms of anxiety along with such manifestations as sweating which he recognized to be of nervous origin, but which he associated with his feelings of inferiority.

At this point, the highlights of the patient's Rorschach test will be informative.

"The patient is a compulsive neurotic with hysterical components present within the general personality configuration. Whatever adjustment he is capable of can only take place within the extremely constricted and rigid mode of behavior he has established. He is completely lacking in any inner stability and resources. His goals are too high for his capacities. He has an overcritical attitude, mostly directed towards himself. He is extremely unsure of his abilities and meets with constant frustration and the feeling of inadequacy. He is unable to find any adequate expression for libido needs and contact hunger. There is a diffuse anxiety picture. There is a marked inability to establish any relationships with persons of either the same or opposite sex. His interpersonal relations were neither free nor spontaneous."

In recounting his past history the patient spoke with great emotion of his mother. She was thirty-six years of age when she married his father, who was three years her senior. At the time of her marriage she was a widow with a ten-year-old son and an eleven-year-old daughter. Her marriage was one of desperation. There was no love, and the patient surmised, very little sex in it. He described his mother as a strict, very fussy person, who was disappointed in his father. She had high standards of competence and success and apparently was quite ambitious for her son, the patient, which the patient believed to be a compensation for her frustration with her husband. The latter was a plodding post-office employee and

a church deacon. He was a cold detached person whose life was filled with religious activities. He had a violent temper of which the patient was a frequent target.

His mother constantly reminded him that she expected him to be a model of success and deportment. She dressed him meticulously and his attire made him the subject of contempt of the other children on the block. When he tried to fight back his parents upbraided him, insisting that they did not want to bring up a ruffian. On the other hand, when he submitted himself he seemed to gain acceptance from his parents. As the baby in the family he enjoyed a dependent relationship with his half-brother and half-sister. He was reared with the idea that great things were expected of him and he tried to comport himself in an exemplary way.

The patient spoke with some guilt of how when his mother first discovered him masturbating, she punished him with a reproachful look in her eyes. This was followed by a grim session in his father's study. His guilt about masturbation continued during adolescence and maturity.

In his desperation the patient discovered that sickness and martyrdom could be utilized as tools with which to cope with authority. Through their use he could be dependent without loss of face. He could play upon the guilt of his parents and when he complained of illness he discovered that the parental ice thawed. The strict rules implacably applied were temporarily relaxed. What open rebellion did not accomplish, sickness and martyrdom magically seemed to be able to achieve.

Coincident with his strivings to gain security through the medium of illness were impulses towards ambitiousness and independence. The latter were, however, submerged under strivings for submissiveness and the need to ingratiate himself with authority with concomitant resentment which was more or less repressed.

There was little question from the material that was presented that tremendous fears arrested the expression of the sexual drive. Any attempt to gratify these sexual impulses filled him with anxiety. Abortive efforts in the direction of sexual liberation mobilized his insecurity and paralyzed his activity. His need for security through the medium of compliance with the parental demands which he interpreted as necessitating sexual abstinence was apparently more important to him than sexual gratification.

With all his inner conflicts, the patient was able to make an adjustment to life, however precarious, until the death of his first wife robbed him of the maternal support on which he had depended for thirteen years.

He recalled how, walking down the street three months after the death of his first wife, he felt as if life was more than he was able to support. He was suddenly overcome with a sharp pain in his back which completely disabled him. It became clear at this point that in returning to the parental circle, with all its inhibiting and competitive connotation, the

patient had also returned to an earlier defense pattern: physical illness. Frightened by his impotence, hopeless about achieving another sexual relationship, he found an escape in his backaches. These, while painful, gave him the excuse for re-establishing the dependent relationship with his mother which otherwise his strict self-discipline and his competitive struggle with his half brother, would have precluded.

It was at this stage in therapy that the patient gained an insight into why it was that he had selected the musculo-skeletal system with which to express, somatically, his psychic disturbance. He began to relate certain emotionally-charged experiences, both recent and more distant, with his symptoms, and to find explanations which he had hitherto overlooked.

After a week of comparative freedom from pain, he had come in to therapy with severe exacerbation of his somatic symptoms. In seeking an adequate explanation for this, he related the story of an extra-marital attempt at coitus which he had recently experienced and which had proved no less vain than former efforts. He then realized that he had suffered from muscle pains in the period that had followed his wife's death, and for the first time he began to see a relationship between this pain and his disappointing sexual activity, his feelings of guilt, his sensation of bearing the burdens of the world on his back.

Still further insight was reached when he remembered that in his childhood, his mother too had complained of lumbar pains, probably hysterical, which, she had asserted, were breaking a back already bent beyond endurance with the intolerable load of life. The patient said that he, too, had sometimes felt similarly martyred.

This interpretation started a new forward trend in therapy, and the patient began to search for other clues relating both to his somatic symptoms and to his inter-personal relationship difficulties. He was particularly puzzled by one apparently anomalous situation. He remarked: "I cannot understand this. Consciously, there is nothing I want so much as to be successful sexually. Yet you tell me that I am unconsciously inhibited. I keep asking myself why this should be."

It was suggested to him that he ask himself this same question every night before sleeping, and see whether dreams might not give the answer.

The next session he brought in a dream which had followed his auto-suggested query.

I was having sex relations with a girl in an oriental place, like a Chop Suey House, and everything was wonderful until suddenly there was a bang on the door and police and gangsters broke in. They were after me. Then I was hiding in an alley. They were coming after me, they were going to kill me. They were on to of me, beating me up, choking me; my chest was caving in. I woke up screaming, confused, covered with cold sweat; my heart was going a mile a minute.

In associating to the dream he gained some further insight into his problem. He saw that in the dream, sex relations were something off-color occurring in an Oriental place. It was a highly dangerous act in which all forces, both of law and outlaw, would attack him. "No wonder," he commented, "that if I want to take a chance on intercourse, my penis won't risk it."

In a subsequent session, he brought in a second dream. *He was sitting at a table in a bar and an older man came in with an attractive woman. She flirted with him and he kept eyeing her but he was afraid of the older men. This man left but still he found himself unable to go with her.* In the next dream-sequence, *he was sitting in a bizarre-looking railway coach next to his mother and yet she looked like a young woman. His father sat across from them at right angles. To his surprise, he ran his hand up his mother's stocking. He couldn't ascertain whether she approved or not, but then he caught his father's eye and withdrew his hand.*

This is, of course, a typical oedipal dream, but the patient was permitted only partially to understand its meaning. At this time he had been in therapy five months on a once-a-week basis. The following are the dynamics of the therapy used.

DYNAMICS OF THERAPY

A brief, modified analytic approach was used in this case. Since the patient was passive and submissive on the conscious level, hostile and resentful below, the therapist employed a permissive attitude of warm understanding. He became the "ideal mother" which the patient had been denied in real life. Since it was his unsuccessful relationship with his mother in childhood which had distorted the patient's character structure, the therapist attempted to help him relive his early traumatic experiences under approving and sympathetic circumstances. Only this positive side of the transference was allowed to develop. Irrational behavior and a negative transference were never permitted to mature.

The patient was encouraged to take his first step forward toward the reality of handling his life situation by three interrelated therapeutic steps.

- (1) The therapist was at all times permissive, uncritical, friendly and accepting.

- (2) The therapist made no exaggerated demands and never held up inordinate goals.

- (3) The patient was given no opportunity to become resentful of the "ideal mother" as he had of the real mother because the

therapist did not impose judgment, yet was invariably helpful and willing to assist the patient solve each problem as it arose.

Since there was no suggestion of authoritarianism in the approach, the patient was not encouraged in his dependency striving, but rather he was strengthened to the point where he could develop his own security and ego strength.

As we have seen, this first advance took the form of accepting and even searching for insights derived both from the therapist and from his own powers of reasoning and self-observation. Formerly he would either have rejected these or accepted them, if offered by the therapist, as a rebuke. Being approved and applauded by the "ideal mother" led to a greater security, a building-up of self-confidence and a willingness to attempt a further step forward.

It was at this point that the patient was able to accept the therapist's assurance that he was doing no wrong in gratifying his sexual urges; that, on the contrary, sexual intercourse was a normal, healthy and socially necessary activity. Nor was it to be considered as an achievement test. It was unnecessary to apply perfectionist standards of accomplishment, but rather to relax in an atmosphere of confident enjoyment. The patient's wife was also interviewed and proved very cooperative. The technic, in this case, proved successful. The patient reported presently that his impotence and premature ejaculation troubled him less and less frequently; that recently he had been able to maintain an erection while his wife had three orgasms.

In summary, this case demonstrates how deep emotional conflict can produce physical symptoms. The dynamics of the patient's character structure are as follows:

(1) At every step in the patient's development from infancy, he was thwarted and frustrated by the rejecting mother. Her excessive demands for conformity and cleanliness, her ambitions, unsympathetic perfectionism and lack of true warmth, made it certain that every stage in his development which required sympathetic weaning from one stage of maturation to the next, would be a struggle.

(2) From early childhood, the patient was constantly in an inner turmoil. In order to be accepted, he had to yield autonomy. In renouncing autonomy, he created inner resentment which in turn had to be suppressed. Whatever course he took generated anxiety and tension.

(3) While each stage of growth was difficult, his mother's attitude to his sexual development was a final and crippling burden.

In the supportive orbit of his first marriage, the patient was able to reach a compromise with life which, while one-sided and unsatisfactory, permitted him to function. When his first wife died and he had to return to the competitive, hostile atmosphere of the parental home, his compromises broke down and he regressed to an earlier defense pattern: psychosomatic illness. Various factors, already outlined, caused the selection of the lumbar region of the spine for the seat of the psychic disorder.

While the brief form of modified analytic therapy employed in this case will not, of course, effect a deep personality change, it may, if successful, be remarkably effective in resolving inner conflicts which have paralyzed the patient in his attempts to find a satisfactory mode of functioning. When somatic symptoms have resulted from tensions caused by these inner conflicts, these, too, may be alleviated.

ACUTE SPASTIC ILEUS ON HYSTERICAL BASIS*

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INTRODUCTION

"The occurrence of spastic ileus in hysterical individuals is rare," says H. J. Tumen in Bockus' textbook "Gastroenterology" (1). Concertedly, the textbook of *Darmkrankheiten* by Schmidt-von Noorden (2) also mentions that spastic ileus occurs only rarely, but it emphasizes that this disorder is relatively frequent in hysterical individuals.

The first case of this sort was reported by Murphy (3) in 1896 when he described the discovery on operation of an intense spasm of a loop of small bowel which returned to normal but had brought about the severe symptomatology of an acute intestinal occlusion thus leading to surgery. Heidenhain (4) in Germany shortly thereafter, in 1897, reported on his experience with the same condition for the first time on the continent. Consequently, a number of cases of spastic obstruction of the bowel have appeared in the literature, and in 1930 Zimmermann (5) collected 159 proved cases from the literature including two cases of his own.

Zimmermann and prior to him Fromme (6) has attempted a classification of the cases as follows: (1) due to the local causes within the bowel; (2) due to reflex causes by the way of the coeliac and inferior mesenteric plexusses; (3) due to causes acting by the way of the central nervous system, including hysteria, etc.; (4) due to a cause not determined.

In order to ascertain the frequency or infrequency of the condition in question in recent years the author of this paper has reviewed the cases of ileus observed at the Long Island College Hospital in Brooklyn, New York, during the past ten years, from 1939-1948. There were only 11 cases filed in this period. One of them, a de facto case of chronic duodenal ulcer with deformation

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and temporary occlusion of the pylorus was unjustly characterized as ileus. The other ten cases were cases of *paralytic* ileus due to a variety of medical or surgical causes. Not a single case of *spastic* ileus was registered, and no case has a psychogenic background.

The apparent rarity of this condition has encouraged the writer of these lines to discuss in the following pages one such case of acute spastic ileus on psychogenic basis which he had the opportunity to observe. The history of this case and its concurrent circumstances may be all the more interesting to gastroenterologists and psychiatrists alike for its climatic revelation of a spastic ileus on a proved hysterical background.

CASE HISTORY

The patient is a 44-year-old white male, jeweller by trade. Born in a European country, he has been a resident and citizen of Panama for the past ten years.

Present History. The patient was first seen in my office on March 1st, 1948. His chief complaints were: Epigastric heaviness and pain radiating to the left shoulder immediately following meals. He also complained of what he termed "gas." He described a retrosternal pressing sensation rising like a ball to and remaining at the larynx, unmistakably a Globus hystericus. His appetite was good, he enjoyed his three regular meals daily, and there was no loss of weight. There was no nausea or vomiting. Occasionally he would have belching or eructations. He complained of 5-6 bowel movements a day, however, with normal, shaped stools and no blood, pus, or mucus ever observed. In connection with his complaint he perseverated that he had suffered from repeated spells of colitis. He claimed that for the past fifteen years he had had, on and off, periods of alternating stools. He also that a prostatitis had been diagnosed in former years. He was a moderate smoker and did not drink any alcohol. Speaking of his sexual difficulties he complained of pain in the testicles which appeared predominantly after frustrated erection, a rather common occurrence.

Previous and Family History. For the sake of a better approach of the events to be discussed later on, it will be necessary to elaborate this part of the case history more broadly than it might be customary.

The patient was born into a neurotic family and brought up accordingly. His father was a man of ill repute, a tinhorn gambler who lost his week's earnings at horse races and at cards. He did not add much to his son's education and was killed in action during World War I, when the boy was ten. His mother whose background was better than his father's could never get along with her spouse and the son was exposed to their continuous marital quarreling from his early childhood. After her husband's death she herself proved too unstable to be a mentor and guide to her son. One sister who was always a "nervous" girl lost her mental balance during the "Blitz" of London and was subsequently institutionalized there.

The growing boy in his emotional needs turned to his mother's brother for psychic shelter and became accustomed to confiding his problems to him. This uncle-nephew relationship grew so binding that it was never completely loosened up to this day. It is possible and probable that this relationship formed the nucleus of the patient's homosexual tendencies which in later life disturbed his heterosexual attachments. Since this uncle was a jeweller, he trained the young man in his trade. Thus he enabled him to go into business at a relatively early age.

Like his sister, the young man was always high-strung and "nervous." At the age of sixteen he developed a peptic (duodenal) ulcer, from which he suffered for ten subsequent years. His craving for affection and his general emotional frustration proved to be the psychosomatic component of this organic condition. During these years the pain grew so intractable that, at the age of twenty-six, the patient had to undergo surgery which consisted of a subtotal gastrectomy. The operation was successful; the function of the gastrojejunal anastomosis is still perfect. (See X-ray picture Plate 1).

The patient described the pain he had suffered during this ten-year period as "severe cramps." We shall refer to this epigastric pain later. It shows a spastic reaction pattern in the patient, a well-known defensive response to emotional upsets and the general feeling of insecurity.

Engaged in business for himself at an early age, the patient felt that he owed it to himself to adopt an adult air and he soon began to go out with girls. In his opinion he was very successful in it. However, the facts elicited subsequently make this statement rather dubious.

At the age of twenty-five the patient married for the first time. This marriage was not successful; it ended in a divorce after a relatively short time. Shortly thereafter the patient left his native country and spent the following years travelling. He did not settle down until he came to the Near East. There he married for the second time. But his nervous unrest and the inner pressures that made him search for unknown gratifications soon took hold of him again. He began to dislike his new home and one day he left the country and his second wife and moved to Switzerland. Whether he ever legally divorced his second wife is not known. He reported however, that while in Switzerland he met a girl who became his third wife. He married her on the grounds of his first divorce papers. Together with his third wife he left Switzerland and moved to Panama. In Panama his third marriage grew more and more unsatisfactory and, eventually, his wife obtained a divorce from him.

No longer to anyone's surprise he married for a fourth time, this time a native of Panama, a halfcast. They were blessed with a child and when this child was four months old the patient made a business trip to New York. He used this opportunity to seek medical advice. This was his second trip of this sort to New York.

Supplementing the patient's history his relatives pointed out that he frequently changed his girl acquaintances and that his respective wives had uniformly confided their complaints about his absolute emotional frigidity. He would fervently court a girl, marry her and except for one or two exceptions, he would never consummate the marriage. The patient himself admitted this and called himself "a sexual neurotic." He did not disclose his specific libidinal fixations and seemed to feel very interesting in his sexual role. He would tell that his recently born child was an unwanted one and suggest that his attitude toward fatherhood was negative.

It was remarkable that rather than having passing flirtations, he appeared to prefer complicated marital relations. They offered him a semblance of emotional security which he was craving. Having had neurotic fixations of long standing, his marriages became empty gestures to prove to himself that he is wanted, loved, and accepted.

The *physical examination* of the patient did not reveal any manifest pathology. He was very well nourished with no sign of any acute distress. There was, however, a moderate degree of anxiety in his entire attitude detectable.

His weight was 160½ lbs., blood pressure: 125/85; the temperature was normal. His lips were moist, the tongue clear, not furred; his teeth were in a fairly good condition with a few molars missing; his throat did not show any abnormality. The heart was not enlarged, there were normal sounds, no murmur; pulse 78. The chest was normal. The abdomen was slightly obese. There was no distension or signs of free fluid in the abdominal cavity. Liver and spleen was not palpable, neither was any mass found. There was moderate tenderness in both the right and left lower quadrants but no rigidity. Upon rectal examination the sphincter appeared to be of good tone; there was no mass, no obstruction, or any other pathology felt. The prostatic gland was normal in size, shape, and consistency. There was no blood on the tip of the retracted finger.

The *tentative diagnosis* of the case was: (1) Psychoneurosis; (2) A marginal ulcer had to be ruled out; (3) Possible chronic colitis or irritable colon; (4) Rule out amebiasis or other tropical infections.

To this end the following *workup* was suggested and performed: (a) X-ray: Gastrointestinal series and barium enema; (b) Laboratory workup including urine analysis; blood Wassermann, and stool for amebae; (c) Proctosigmoidoscopy; (d) Urologic consultation.

Proctosigmoidoscopy was done first and the findings were absolutely negative. *X-ray workup* was done subsequently; it rendered the following result:

The roentgen examination of Mr. R. S. was made on March 8, 1948.

Region examined: gastro-intestinal tract

Mode of examination: fluoroscopy and radiography

The fluoroscopy of the chest shows no abnormalities. The esophagus is well outlined. The cardia lies about 1 cm oral to the esophageal hiatus.

The stomach is partially resected. The stump of the stomach is well outlined and its mucosal pattern shows no abnormalities. A small part of the cardiac portion of the stomach is herniated through the esophageal hiatus into the posterior mediastinum.

The stomach empties through an enterostomy. The mucosal folds in the region of the enterostomy and in the upper jejunum are regular.

The stomach empties normally. The examination 4 hours after the ingestion of the barium meal shows the head of the meal at the transverse colon. The small intestines, including the terminal ileum are well outlined. Their mucosal pattern shows no abnormalities.

The examination 24 hours after the ingestion of the barium meal shows the colon practically emptied.

Barium Enema: The entire colon is well filled and outlined.

The examination after evacuation shows the colon well emptied. The colon is rather spastic. The mucosal folds throughout the colon are thickened. No other abnormalities can be seen in the region examined.

The terminal ileum is well outlined. The appendix can not be visualized.

Remarks: Spasticity of the colon and probably low grade of colitis; small herniation through the esophageal hiatus. (See plates 1-4.)

The *laboratory reports* rendered normal findings. The examination for amebae and other protozoa was performed from repeated warm stools in the Laboratory for Tropical Diseases of the City of New York (Dr. Shookoff). No amebae or other protoorganisms were found.

A *neurologic consultation* yielded no pathologic findings. The patient's impotence was presumed functional and psychogenic, a part of an underlying psychoneurosis.

DIAGNOSIS

1) Small hiatal hernia; 2) Well functioning gastrojejunal anastomosis; 3) Spastic and irritable colon; 4) Psychoneurosis.

THERAPY

The patient learning the results of his various examinations, felt better and was reassured and discharged with sedatives—anti-spasmodics.

ILEUS

On his way from Panama to New York, the patient had stopped over in Miami, Florida, for a few days. Here he met a New York woman whom he dated immediately after both their arrival to this city. I had the opportunity to meet this woman during the coming events and she confided to me that her relation to our patient had grown serious. In fact, he proposed to marry her after he had settled his affairs.

Not quite three weeks after his first visit the patient returned to my office with the complaint of severe heartburn and backache and lower abdominal distress. He had overindulged in eating the night before and felt miserable. He was undecided, however, whether he should blame the opulent meal or a frustrated attempt of intercourse for his condition. He stressed the point, however, that this pain in the lower abdomen now was exactly like the epigastric pain he used to have during the ten-year period of his duodenal ulcer, only—as he expressed it—the pain had shifted further down.



Plate 1 shows a small hiatal hernia; a well functioning gastrojejunal anastomosis after subtotal gastrectomy; the small bowels offer a normal pattern without organic obstruction.



Plate 2 shows the head of the barium meal in the transverse colon after 4 hours. The small intestines reveal normal mucosal pattern and fail to suggest any organic obstruction.

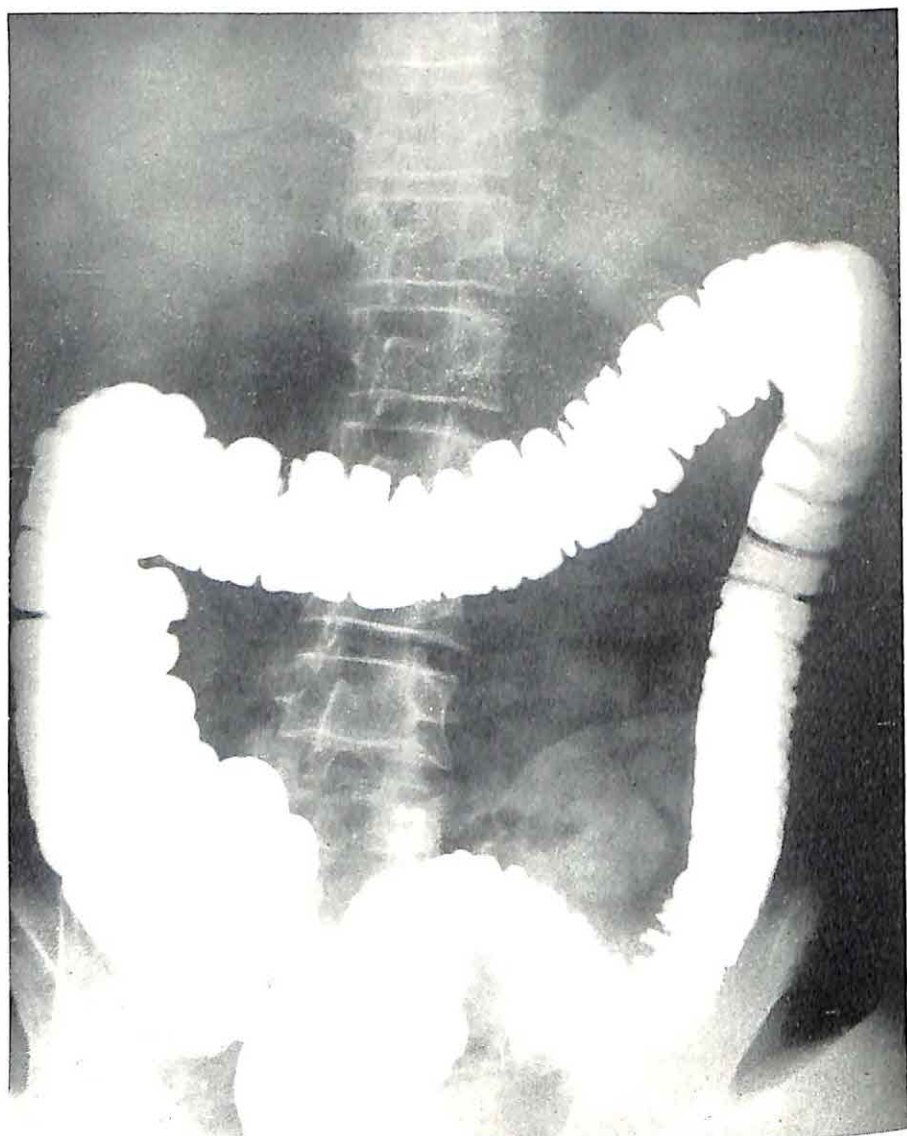


Plate 3. Colon demonstrated by barium enema; normal appearance; no sign of organic obstruction.

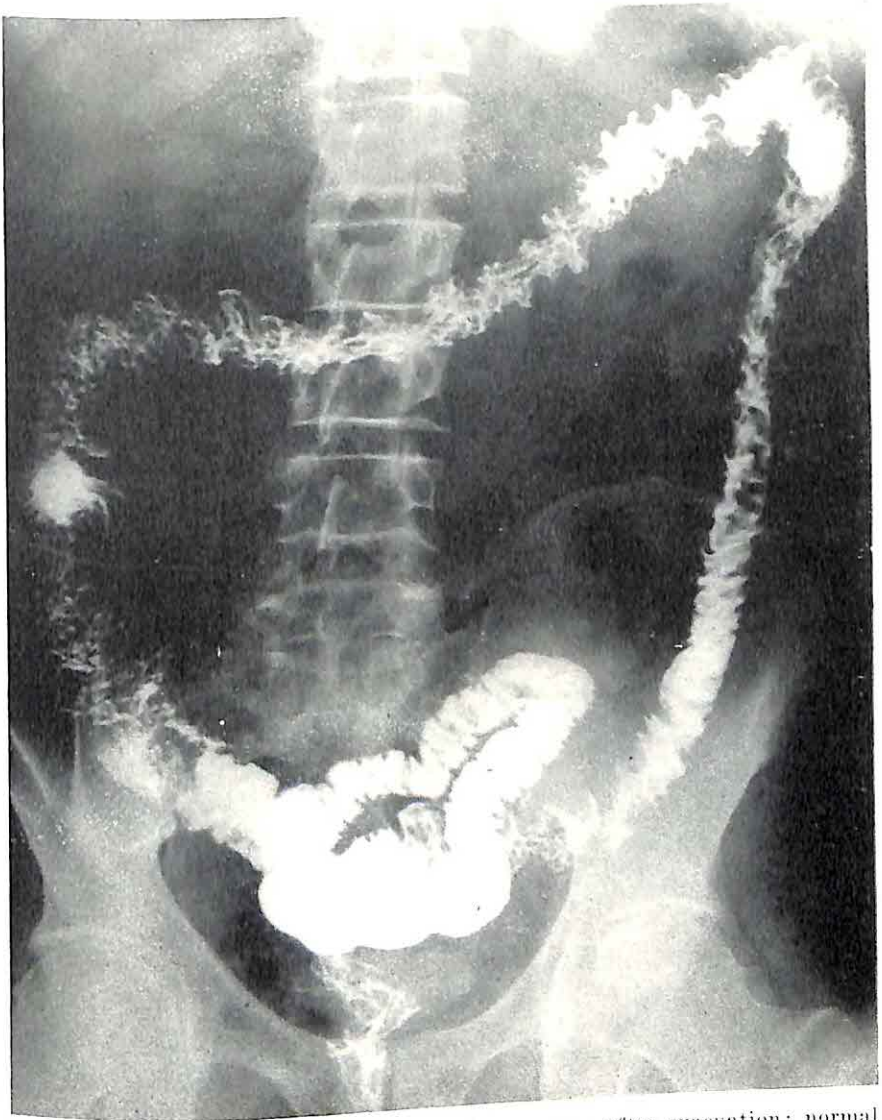


Plate 4. Colon demonstrated by barium enema, after evacuation; normal mucosal pattern, no organic obstruction.

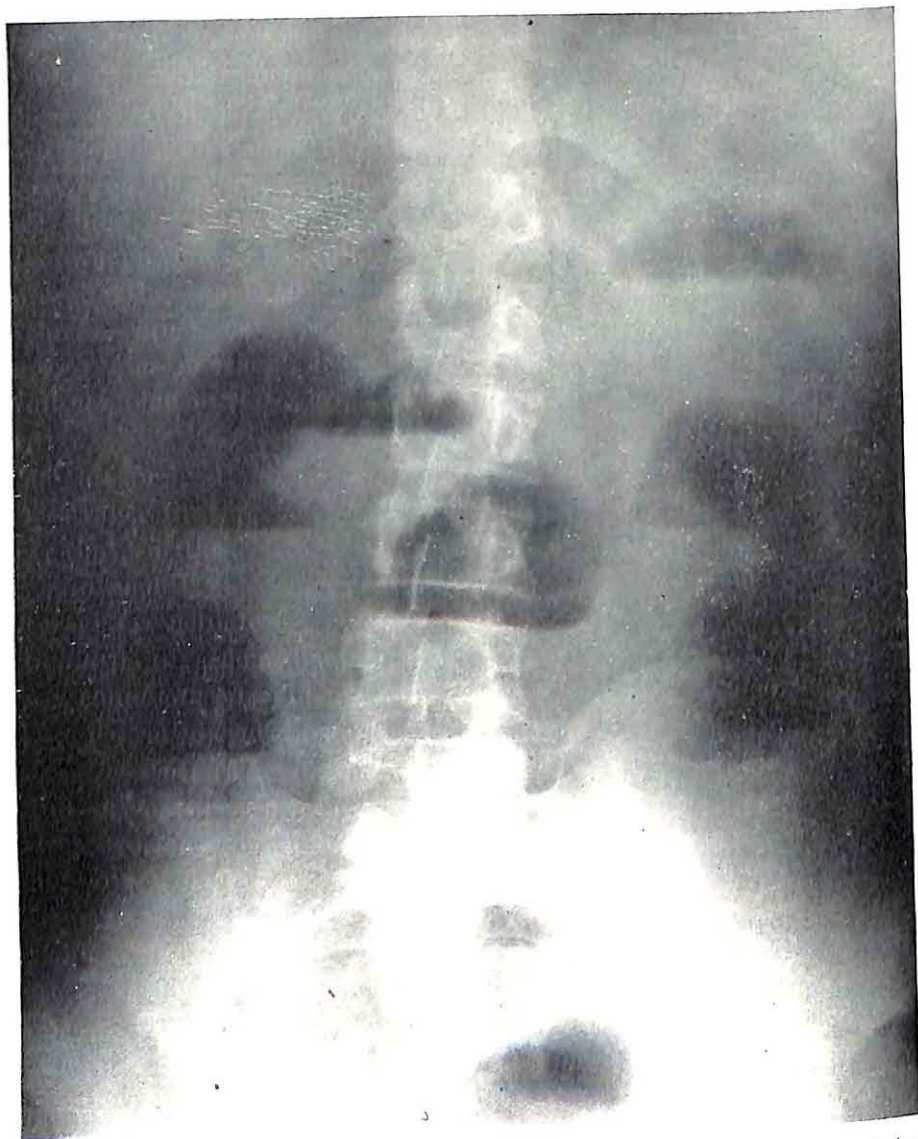


Plate 5. Flat plate taken in erect position indicates distended small in testines with fluid levels in four layers. The colon is not visible.

The examination of his abdomen was negative. The abdomen was soft, there was no resistance and only a moderate epigastric tenderness. The patient was discharged with reassurance and a compound sedative antispasmodic.

The same night I received an urgent call to see him at his hotel. The story I was able to elicit was as follows: He was on his way to Atlantic City when he suffered an attack. He was in the company of his lady acquaintance with whom he planned to spend a holiday. At the station, shortly before boarding the train, he suddenly felt a severe abdominal pain and nausea, which incapacitated him so much that he refused to return to his own hotel and took a room at a neighboring hotel. Once in his room he felt miserable and began to vomit. Up to the time of my arrival he had vomited a number of times, and was in a stage of severe anxiety. He feared his approaching death and carried on accordingly. He complained of severe pain, but he localized this pain in the epigastrium, in the lower abdomen, and then again in the midabdomen and the back, respectively. His abdomen was flat and soft; there was no marked or stable tenderness, no rigidity or mass. There was no rectal tenderness. The temperature was normal and the pulse was good.

In view of his complex history, his recent complete workup which yielded but negative results and the present lack of pathological signs, an attempt was made to restore the patient's courage by verbal suggestion. In addition, he was again put on sedatives and spasmolytics.

He slept a few hours during the night but continued to complain of pain in the morning. Vomiting recurred. He had vomited food, fluid, and bile at first. Now he brought up gushes of water-like fluids although he had ingested nothing. He also claimed to be obstipated for the third consecutive day.

On my arrival on the following morning the patient offered an entirely different and alarming picture. He appeared to be dehydrated. His face was drawn and slim and his expression was what is called a "facies abdominalis." His tongue was dry and coated. His abdomen was moderately distended and there was tenderness in the upper parts of both lower quadrants. There was moderate rigidity, and an indistinct resistance was palpable. The patient appeared to be visibly weakened and in great fear. His temperature was 101.0, his pulse 120 and small.

While under examination he again vomited fluids in a projectile manner—light yellow-brown in color and of putrid fecal odor. This

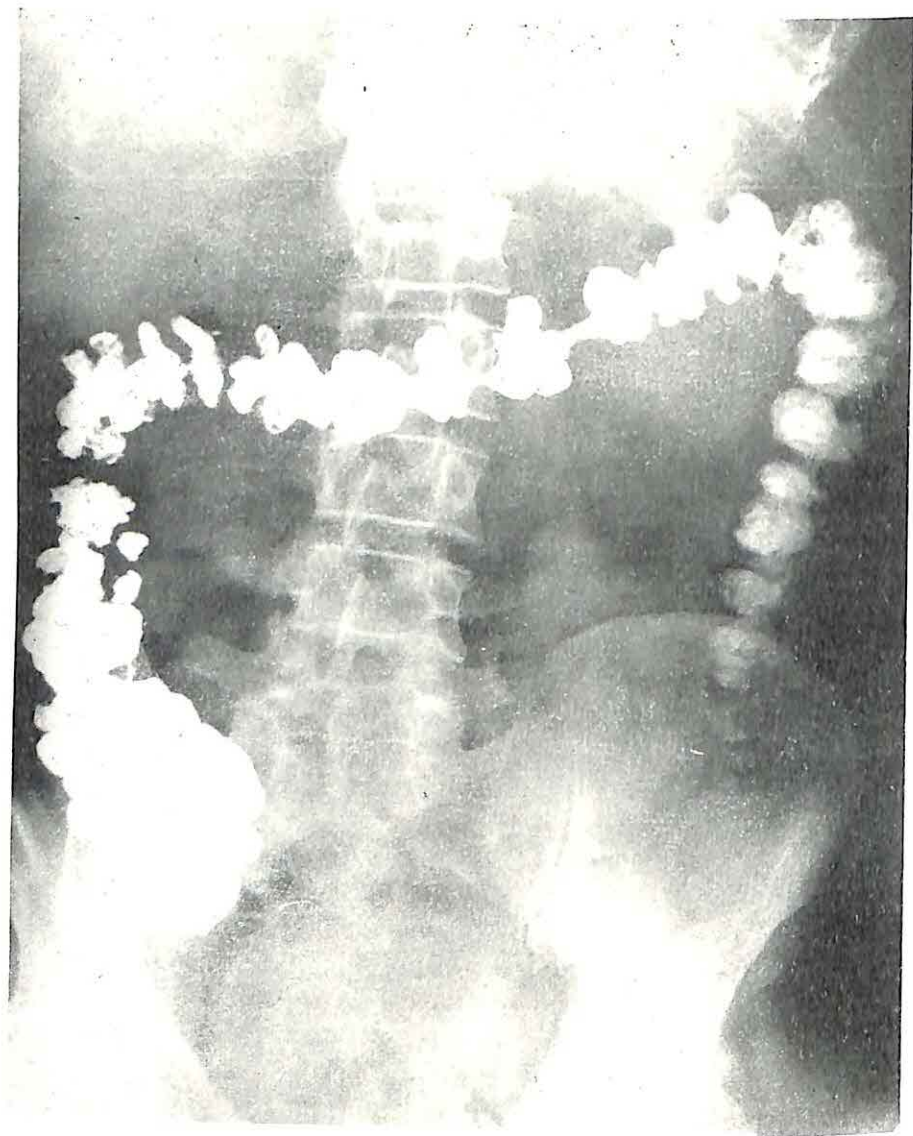


Plate 6. Colon taken after the attack shows moderate spasticity but fails to indicate any organic obstruction.

miserere confirmed the tentative diagnosis of an acute intestinal obstruction. Thereupon the patient was moved to the hospital. A flat plate immediately taken indicated fluid levels in four layers in the extensively distended small intestines; no gas was visible in the colon. These findings made the diagnosis of an acute intestinal obstruction evident. (See X-ray picture Plate 5.)

A surgeon was called in for consultation and after a thorough appraisal of the patient's history and his recent clinical workup, a conservative attitude in his treatment was agreed upon. The patient was kept for 48 hours with a Miller-Abbott tube and with a continuous glucose-saline-vitamin C infusion. Enemas were administered repeatedly and failed to show bloody returns. After three days flatus and evacuation returned, the abdominal distension and tenderness vanished gradually and the temperature and the radial pulse returned to normal. The patient recovered quickly and completely.

Two weeks after the patient's complete recovery his X-ray workup was thoroughly repeated and no trace of any organic obstruction was found. There was only a moderate spasticity of his colon present.

SUMMARY

A case of acute spastic ileus has been described. An attempt was made to explain the patient's present condition as a result of his psychoneurotic background and his pathologically unstable character. His neurosis manifested itself predominantly in a sexual maladjustment. The exact cause of it could not be ascertained, but it is safe to assume that the patient's emotional insecurity and quest for affection on the one hand and the spastic pattern of his neurotic defense reactions on the other hand offered the psychosomatic background for a spatic ileus which as such became an acute medical emergency.

In consideration of these facts a conservative treatment was applied which proved entirely successful.

BIBLIOGRAPHY

- (1) H. J. Tumen in Bockus' *Gastroenterology*, page 327, 1945.
- (2) Schmidt-von Noorden, *Klinik der Darmkrankheiten*, J. F. Bergmann, Muenchen, 1921.
- (3) Murphy, *J.A.M.A.*, 26: 15, 1896.
- (4) Heidenhain, *Archiv f. clin. Chirurgie*, 55: 211, 1897.
- (5) Zimmermann, *Surg. Gynec. Obstetrics*, 50: 721, 1930.
- (6) A. Fromme, *Deutsche Zeitschrift fuer Chirurgie*, 126: 579, 1914.

NOTES AND COMMENTS

Programs of Psychiatric Societies

All medical groups of psychiatry and psychotherapy are herewith invited to send us their programs and brief reports on their current scientific activities. AMERICAN JOURNAL OF PSYCHOTHERAPY will be pleased to publish these notices gratuitously.

Meetings

The *American Society for Research in Psychosomatic Problems* held its annual meeting in Atlantic City, N. J., on May 1-2. Franz G. Alexander, M.D., of Chicago, Ill., presided. The subjects discussed were diabetes, genito-urinary and gynecological problems with their psychosomatic aspects, also problems of research and methodology.—The *National Advisory Mental Health Council* (Chairman Edward A. Strecker, M.D.) which makes recommendations to the Surgeon General in the field of mental health held a meeting in Washington in May 1948. The agenda included Community Services (Chairman S. Alan Challman, M.D., of Minneapolis, Minn.), and Research (Chairman Nolan D. C. Lewis, M.D., of New York, N. Y.). Training and research grants, for which applications under the National Mental Health Committee Act have been made, were under consideration.—At a meeting of New York Medical College William V. Silverberg, M.D., associate clinical professor, read a paper on "Reformulations in the Theory of Neurosis."

The ninth Annual Meeting of the *Rorschach Institute* was held at Temple University in Philadelphia on Saturday, April 17th, 1948. Papers were read and discussion centered upon two main topics: "*Problems of Quantification and Objectification in Personality Measurement and Diagnosis and Handling of Borderline Schizophrenia.*"

At the business meeting a new Constitution and By-Laws were adopted whereby the organization broadened its objectives to include all projective methods of personality diagnosis. Henceforth psychologists and psychiatrists qualified and primarily interested in projective methods other than Rorschach may become members. It was voted to change the name of the organization to 'The Society for Projective Techniques and the Rorschach Institute, Incorporated.'

Newly-elected officers of the Society are: Theodora Abel, President; Solomon Machover, Vice-President; Bessie B. Burgemeister, Treasurer; Edward M. L. Burchard, Secretary; Bruno Klopfer, Editor; Camilla Kemple, Executive Editor.

The Sixth Annual Conference of the *American Group Therapy Association* will be held Friday and Saturday, January 21 and 22, 1949 at the Einhorn Auditorium, Lenox Hill Hospital, New York. One session of the conference will be devoted to an analysis of the nature of leadership in ordinary groups and therapy groups. A number of sociologists and psychotherapists have been invited to participate in this symposium. Dr. S. H. Foulkes from London, England, has consented to come to the United States to deliver one of the main papers in this symposium. The topic of another session is "Contemporary Research in Group Psychotherapy." Papers dealing with "Basic Dynamics in Analytic Group Psychotherapy," "Regression in Activity Group Therapy" and "Resistance in Analytic Group Psychotherapy" will be presented. Among the participants are Hyman Spotnitz, S. R. Slarson, Betty Gabriel and Harriet Montague. Three Round Tables on specific aspects of Group Therapy are also being planned. Preceding the main conference, an all-day conference has been arranged for Friday, January 21st, 1949 for staffs of mental hospitals exclusively to explore the specific problems in Group Therapy in such institutions. The Association's address is 228 East 19th Street, New York 3, New York.—To the list of Medical Specialty Societies in the Bronx, there has been added that of *The Bronx Society of Neurology and Psychiatry*. This society has been recently incorporated and at present has 36 members. The officers are: Joshua H. Leiner, M.D., President; Nathan Savitsky, M.D., Vice-President; Jacob H. Friedman, M.D., Secretary; Moses Madonick, M.D., Treasurer. The executive committee members are: Hilbert W. Ehrlich, M.D., Nicholas R. Locascio, M.D., and Joseph D. Sullivan, M.D.

Appointments

Col. John M. Caldwell, M.C. and Lieut. Col. Stephen C. Sitter, M.C., associate professors of the Consultants Division and Surgeon General's Office respectively have been appointed clinical professors of psychiatry at Georgetown University, Washington, D. C.—The U. N. Economic and Social Council has appointed Manfred S. Guttmacher, M.D., of Baltimore, Md., psychiatric consultant to the World Health Organization Interim Commission. His special assignment is the study of the prevention of crime and the treatment of offenders, so that action plans on an international scale can be put into effect. Dr. Guttmacher's work comprises heredity prophylactics, medical and psychological aspects of therapy of juvenile and adult offenders.—Harvey J. Tompkins, M.D., of Arlington, Va., has been appointed head of the neuropsychiatric service in the department of medicine and surgery of the Veterans Administration to succeed Daniel Blain, M.D., who has resigned to become medical director of the American Psychiatric Association.—Nils B. Hersloff, M.D., chief of the neuropsychiatric division of the Veterans Administration's medical service

in New York, has been appointed manager of the V. A. in Canandaigua to succeed Hans Hansen, M.D.—*Frederic Wertham, M.D.*, director of the Mental Hygiene Clinic at Queens General Hospital and the Lafargue Clinic of Harlem, has been appointed Director of the Readjustment Center of the Quaker Emergency Service, New York, N. Y. The Readjustment Center is a psychiatric service for individuals who, because of their sexual disturbances, get into conflicts with society, especially homosexuals. The center functions under the auspices of the Magistrates Court of the City of New York, (the Hon. Edgar Bromberger, Chief Magistrate).—*Clinton P. McCord, M.D.*, of Albany, has been appointed consultant on psychosomatic medicine to the N. Y. State Department of Health.—*Fredrick C. Redlich, M.D.*, of Yale University School of Medicine, New Haven, Conn., was promoted to associate professor, department of psychiatry and mental hygiene.—*James M. Cunningham, M.D.*, lecturer in psychiatry and mental hygiene, was promoted to the rank of associate professor.—*Mildred H. January, M.D.*, to assistant clinical professor of pediatrics and psychiatry and mental hygiene, of Yale University School of Medicine.—*Otto Lowenstein, M.D.*, clinical professor of neurology at New York University College of Medicine, received the appointment as professor of neurology at Columbia University College of Physicians and Surgeons. The members of the Association congratulate Dr. Lowenstein, a former member of their Board of Directors.

Awards

The National Committee of Mental Hygiene (Director George S. Stevenson, M.D.) will present the 1948 Lasker Award of \$1,000 for a recent significant contribution to the education of the physician in the psychological aspects of the practice of medicine. The presentation will take place at the annual meeting of the National Committee to be held in New York November 3-4. The work must have been accomplished and generally accepted during the past two years. Nominations may be submitted not later than September 1 to the National Committee of Mental Hygiene, 1790 Broadway, New York 10, N. Y. Further information on request.—*Winfred Overholser, M.D.*, superintendent of St. Elizabeth's Hospital, Washington, D. C., received a Certificate of Appreciation from the Bureau of Medicine and Surgery, in recognition of the services rendered by Dr. Overholser and the Hospital to the Medical Department of the Navy during the War.—*Russell E. Blaisdell, M.D.*, the retiring superintendent of Rockland State Hospital, Orangeburg, N. Y., was honored by the employees, members of the board of visitors, and residents of the institution. Dr. Blaisdell served forty-two years with the Department of Mental Hygiene in New York.

Deaths

Charles H. Heninger, M.D., professor of psychiatry at the Western Pennsylvania Medical College, one-time president of the Medical Society

of the State of Pennsylvania, died at the age of seventy-three in February 1948, of coronary occlusion.—*Edwin John Doty, M.D.*, assistant psychiatrist at New York Hospital, died in March 1948 at the age of forty-five.—*George W. T. Mills, M.D.*, of Brooklyn, N. Y., formerly superintendent of Brooklyn and Creedmore State Hospitals, died in May 1948 at the age of sixty-eight.—*Otto Marburg, M.D.*, of New York, clinical professor of neurology at the College of Physicians and Surgeons, Columbia University, author on many standard books on neuroanatomy and neuropsychiatry, died in June 1948 at the age of seventy-four. He won international reputation with his studies on epilepsy and amaurotic idiocy. A victim of Nazi persecution, he came to this country in 1938 from Vienna, where he had been director of the Neurological Institute since 1919.—*Charles A. Elsberg, M.D.*, one of the founders of the N. Y. Neurological Institute, former professor of neurologic surgery at the N. Y. Postgraduate Medical School and Hospital, Columbia University, a recipient of many prizes and medals for his scientific achievements, died in March 1948 of coronary thrombosis. He was seventy-six years old.

Mental Hygiene

The Mental Hygiene Division of the Public Health Service released the following figures on the *population of mental hospitals* at the end of 1946: Of every 100,000 persons of the civilian population in the continental United States 382.4 were in hospitals to which they had been admitted for prolonged care. 518,672 were in hospitals at the beginning of the year, and this number increased by 10,575, about 2%, during the twelve months. There were 153,025 first admissions during 1946.—Funds provided by the U. S. Public Health Service have made it possible for the *Maryland State Department of Health to organize a Division of Mental Hygiene*. The division which has been operating since early January 1948 holds clinics in seven counties and expects to add two more counties to the list in the near future. *Kenneth B. Jones, M.D.*, has been assigned as Chief of the Division of Mental Hygiene of the State.—The U. S. Public Health Service announces that a limited number of *mental hygiene fellowships* for graduate work will be awarded. The fellowships are open to psychiatrists, psychologists, social workers and other qualified persons interested in research in mental health. These fellowships will be at the predoctorate and postdoctorate levels, while a special *research fellowship* will be awarded to applicants who qualify for a postdoctorate fellowship and who in addition have demonstrated outstanding ability or who possess special training; this particular fellowship does not carry a set stipend. The stipends vary from \$1,200 a year to \$3,600, depending on the applicant's qualifications and the number of his dependents. Applicants are required to file a statement outlining the investigation on which they will work. Requests for informa-

tion should be addressed to Division of Research Grants and Fellowships, National Institute of Health, Bethesda 14, Maryland.

Research and Training

Under the auspices of the Public Health and Commonwealth Fund, a *Pilot Institute on Mental Health*, was held in Berkeley, Cal., July 5th through the 18th. The sessions included lectures and seminars in public health activities, and were held for the benefit of Public Health officers of the East San Francisco Bay region.—The *Research Council on Problems of Alcohol* (Joseph Hirsch, director) has granted \$30,000 to Cornell University Medical College (Oscar Diethelm, M.D., director) to further studies on causes and therapy of alcoholism. The Research Council also granted \$20,000 to New York University College of Medicine, Department of Medicine (James J. Smith, M.D., director) for a study of biochemical and endocrinological factors in alcoholism.—The Carnegie Corporation has made a grant to the *Cornell University* to inaugurate a program of training psychiatrists in *industrial and labor relations*. A fellowship will be provided to physicians with experience in psychiatry for a two-year training at the School of Industrial and Labor Relations. The training includes courses in basic industrial and labor relations, in human relations work in plants, labor unions and government offices. The *Psychodramatic Institutes of Beacon and New York City* have organized seminars for the teaching and training of students, covering the fields of psychodrama, sociodrama, sociometry, group psychotherapy and other action methods as they apply to Education, Child Guidance, Adolescent Deviation, Intercultural Relations, Family and Marriage Problems, Political and Labor Conflicts, Community and Religious Problems. The summer seminars begin June 1, and last until October 31. The training course is divided into special seminars, each lasting four weeks. For further information write to: Moreno Clinic, Beacon, N. Y.

Institute for Research in Psychotherapy, Inc.

The *Officers* of the Institute are: Lewis R. Wolberg, M.D., President; Emil A. Gutheil, M.D., Vice-President; Joseph Wilder, M.D., Secretary; William Wolf, M.D., Treasurer.

The *Medical Advisory Board*: Julius Bauer, M.D., Carl Binger, M.D., Daniel Blain, M.D., Karl Bowman, M.D., Kurt Goldstein, M.D., Hartwig Kahlenbeck, M.D., Nolan D. C. Lewis, M.D., Wendell S. Muncie, M.D., Thomas A. C. Rennie, M.D., and Edward A. Strecker, M.D.

The *Non-Medical Professional Advisory Board*: Ruth Benedikt, Ph.D., Eugene A. Bewkes, Ph.D., LL.D., Molly Harrower, Edwin Lukas, LL.B., Robert McIver, Ph. D., and Rev. Charles Potter.

Heads of Departments: Director of Training: Stephen P. Jewett, M.D.;

Director of Education: Emil A. Gutheil, M.D.; Director of Clinics: Lewis R. Wolberg, M.D.; Director of Research: Irving Bieber, M.D.

Registration: September 20, 1948. Classes begin October 4, 1948.

Information: 218 East 70th St., New York 21, N. Y.

The Institute has been entered as a Commission at the International Congress on Mental Health which will be held in London from August 11th through August 21st, 1948. The preparatory Bulletin No. 9 lists our Institute in the fourth group of the Commissions. The topic listed is: "Training, therapy, research and education in psychiatry." Irving Bieber, M.D., is the speaker of the Commission.

Back Issues of the Journal Wanted

AMERICAN JOURNAL OF PSYCHOTHERAPY will pay \$2.50 for copies of the *July 1947 issue*. Please mail your spare copies to the Editor, Emil A. Gutheil, M.D., 16 West 77th Street, New York 24, N. Y.

Psychotherapy with Veterans

A *speech training program* will be available for veterans under P. L. 16 in various clinics, hospitals, and schools of the Nation, according to an announcement by the Veterans Administration. The training will be offered to those veterans who because of speech impairment are handicapped in obtaining or maintaining adequate employment.—The increase in the number of Veterans Administration hospitals, addition of mental hygiene clinics for outpatient treatment and other improvements begin gradually to bear fruit. For the first time in history, *the number of patients discharged from the V. A. neuropsychiatric institutions* between July 1947 and April 1948 exceeded that of the admissions. A number of new and effective policies have been introduced. They include establishment of neuropsychiatric units in general hospitals, establishment of general medical units in neuropsychiatric hospitals, use of shock therapies, narcoanalysis, and lobotomy, extensive use of psychotherapy, both individual and group psychotherapy, educational programs, residency training, introduction of "team techniques" (psychiatrist, psychologist and psychiatric case worker), establishment of a clinical psychology program, wide use of volunteers in the development of a public educational program, setting up of research programs, establishment of special laboratories for psychosomatic studies and intensive rehabilitation for chronic patients.

Legislation

A bill (S. 135) providing for the creation of a *board of examiners for the certification of clinical psychologists* was approved on March 25, 1948, by the State of Kentucky.

Review of Opinion

THE AMERICAN JOURNAL OF PSYCHOTHERAPY will at intervals publish a poll of opinion on important questions of psychotherapy. Please let us know your views, and also send in questions you wish to submit to our readers. Address your replies (not more than 1000 words) to THE EDITOR.

QUESTION NO. 5

What is the social responsibility of psychiatrists in view of the ever-rising quantity of comic books which glorify violence, sadism and torture?

Replies to Question No. 4*

Dear Editor:

The problems of constitutional predisposition and of hereditary factors in psychoneuroses have been frequently examined in the past. The results are expressed in statistical terms suggesting the average percentage of hereditary tainting in the various forms of psychoneuroses. To my, admittedly limited, knowledge it has not been examined to what extent the ascertained heredity affects the psychotherapeutic prognosis. I am now scrutinizing my own material and am trying to arrive at some definable conclusions.

Naturally, in such an examination one cannot proceed but on the hypothesis that one's own technique and experience has been adequate for the achievement of good therapeutic results, whenever such a favorable outcome has been possible in view of the characteristics of the case. (That is, in view of the deeper structure of the neurosis as well as the fundamental personality of the patient.) Therefore, it is necessary to exclude from the survey unsatisfactory results where it may appear that they were due to erroneous judgment and technical inadequacy in handling the case, or to other circumstances preventing the improvement at that particular period. However, we cannot deny the somewhat limited value of conclusions based on any therapist's own results, unless we believe that his technique is indeed the very best, an assumption so difficult to maintain.

Nevertheless, conclusions regarding our problem, drawn from successfully treated cases, are free from this error. A number of patients with clearly established heredity (psychoneurotic or psychotic) have been cured, or made free from symptoms, for a number of years. Here we must realize that there cannot be too fixed a relationship between "hereditary findings" on the one hand and the "psychotherapeutic prognosis" on the other. A

* **To what extent do constitutional factors in psychoneurosis influence your conduct in psychotherapy?'' Submitted by Sidney Elpern, M.D., of New York. Cf. October, 1947, issue of this JOURNAL.

similar state of affairs prevails in respect to the efficacy of treatment by convulsions and by insulin coma. It has been frequently reported that heredity does not affect the fair therapeutic prognosis in the majority of such cases.

In other words, the factor of heredity plays a role in the prognosis only to the extent to which it has really been transmitted. The predisposition to an illness on the one hand and the degree of its curability on the other need not be inherited to an equal measure. The dynamic significance of the predisposition can hardly be assessed otherwise than by the degree to which the patient is manifestly incapacitated as well as by the ease and extent to which he responds to treatment.

There are patients with strong hereditary tainting who were suffering for years from anxiety attacks, phobias, or obsessions, but were still able to work and enjoy a measure of inconspicuous social life, because auto-suggestive efforts, or alcohol, or drugs, helped them to camouflage their symptoms. If such cases improve through psychotherapy despite the long duration of complaints and the tainted family history, then we must realize that the central factor that matters is the patient's basic mental structure. If a patient's personality has not been overpowered by his neurosis in spite of multiple heredity (and severe traumas) it is obvious that the incidence, character and frequency of mental illnesses in relatives matters much less than the subject's own psycho-affective resistance. This intrinsic resistance is clearly displayed when strong traumas and multiple heredity result in a type of psychoneurosis which does not render the patient greatly disabled.

My material suggests that heredity may affect the psychotherapeutic prognosis in cases where the morbid picture appears to be "massive" in character. But this latter fact is obviously the result of the personality's weakness, which may or may not be identical with the transmitted element. However, it would not be surprising if the survey of a large material would show that the significance of ascertained heredity in the therapeutic prognosis is, to a certain degree, different in various types of psychoneurosis. I feel that *the character and duration of traumas* is of too great a significance and that it may complicate our judgment as to whether or not in a particular case it is the hereditary factor which has been responsible for the therapeutic difficulty.

Regarding the problem of therapeutic prognosis it is well to remember that there is a difference between psychoses and psychoneuroses. In the former category spontaneous recovery is frequent and in the majority of cases only speeds up this ultimate outcome. Spontaneous recovery in psychoneuroses is rather infrequent and the role of an adequate therapy is thus doubly significant. Therefore, an examination of the relationship between heredity and therapeutic prognosis in psychoneurosis is a more involved task. For the same reason the adequacy of treatment in each individual case is more important than in the shock treatment of psychoses.

I should be grateful if other readers would communicate their experiences and impressions in this matter.

DR. SAMUEL LOWY

London, England

A Monograph Series of the Journal

AMERICAN JOURNAL OF PSYCHOTHERAPY will soon publish two monographs. The first will be *Wilhelm Stekel's* "Autobiography," which will include all installments appearing in this Journal. The second monograph will be "Diagnostic and Therapeutic Value of Projective Techniques" by *Paula Elksch, Ph.D.*

Child Psychiatry

The "Institute of Living" in Hartford, Conn., has started construction of an *Institute of Child Psychiatry*. The directors of the Institute plan to introduce a new idea into Child Psychiatry by establishing a "Parentorium" for the guidance of parents of emotionally disturbed children. The new Institute will contain classrooms, treatment rooms, gymnasium, shops, etc. It will accommodate more than sixty children.—Another center of the treatment of emotionally disturbed children has been opened at *Adelphi College* under the direction of John C. Thurrott, M.D., of New York College, Garden City, N. Y. A number of maladjusted children will be treated on a fee basis. In addition to therapy, the center will engage in research training, social work and education. Physicians and graduate nurses interested in psychological treatment of children will be provided with an opportunity to obtain clinical experience.—The American Association of Psychiatric Clinics for Children under the auspices of the U. S. Public Health Service, the Commonwealth Fund and some local funds, offers fellowships of *training in child guidance and clinical psychiatry*. The fellowships are for 1-2 years. Candidates must be graduated from an approved medical school, and must have had a general introduction and two years of psychiatric experience. Information can be obtained from *Abraham Barhash, M.D.*, American Association of Psychiatric Clinics for Children, 1790 Broadway, New York 19, N. Y.—The International Committee on Mental Hygiene received a research grant of \$20,000 (under the National Mental Health Act) for a study on *the effect of war on children*. David Levy, M.D., of New York, N. Y., will conduct this study and report on it at the International Congress on Mental Health in London.—*Dr. Margaret Lowenfeld*, one of the leading child psychiatrists in Great Britain, is arranging an *international technical conference* which will take place in London from August 3rd to August 9th, between the International Psychological Conference in Edinburgh and the Mental Health Congress in London. At this technical conference projective methods and tests used at the Children's Centre of the Institute of Child Psychology (London) will be demonstrated.

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THE EDITOR

EXCERPTS FROM THE CONSTITUTION OF THE ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOTHERAPY

MEMBERSHIP

"Any person shall be eligible for membership in this Society if he

"(A) is a licensed physician in good standing, a psychiatrist, or in psychiatric training or has evidenced an interest and activity in psychotherapy and has been proposed by a member in good standing and approved by the Committee on Admissions; or

"(B) has been invited to become a member by the Committee on Admissions by reason of a valuable contribution towards the advancement of psychotherapy although not a licensed physician.

"A member of this organization who is not a licensed physician shall be an 'Associate Member.' Such a member shall have the same rights and privileges as other members with the exception of the power to vote or hold elective office."

DUES

"Annual dues of the Society shall be three (3) dollars payable to the Association for the Advancement of Psychotherapy and forwarded to the Secretary-Treasurer on the first day of January for the ensuing year. Any member who fails to pay his dues within thirty days after notification by the Secretary-Treasurer shall be automatically stricken from the list of members. Applicants for membership shall pay the dues for the full year in which their application is submitted."

According to the decision of the Board of Directors an application for membership must be accompanied by the tender of the membership fee, *plus* the price of a membership subscription to the Journal.

PROCEEDINGS of the ASSOCIATION FOR THE ADVANCE- MENT OF PSYCHOTHERAPY

SCIENTIFIC SESSIONS

At the April 30th, 1948, session of the Association *Walter S. Boernstein, M.D.*, read a paper entitled "The Role of Unconscious Processes in the Analytic Procedure and in Productive Thinking." In the discussion that followed Drs. *Johann G. Auerbach*, *Max W. Friedemann*, *Edith Klemperer* and *Joseph Wilder* participated.

On May 21st, 1948, *Alexander Wolf, M.D.*, read a paper entitled "The Psychoanalysis of Groups." This interesting presentation was followed by a discussion in which Drs. *Paul Goolker*, and *Alfred Schick* participated.

The fall season of the Association will be inaugurated on October 29, 1948, with the presentation of "Psychiatry and the Science of Economics" by *Joseph Wilder, M.D.*, and *Dr. Albert Lauterbach*.

SEMINARS

The following Seminars will be held in the Fall:

Emil A. Gutheil, M.D.: "Practice of Active Analysis." A ten-session Seminar.

Frederic Wertham, M.D.: "Practice and Theory of the Mosaic Test." A four-session Seminar.

Full details about time and place of these Seminars will be announced at a later period.

THE PSYCHOPATHOLOGY OF COMIC BOOKS

*A Symposium**

FREDERIC WERTHAM, M.D.

New York, N. Y.

INTRODUCTION

Psychiatry was practiced intramurally in institutions originally.

* The following is an abstract of the symposium held by the Association for the Advancement of Psychotherapy on March 19, 1948.—*Frederic Wertham, M.D.*, introduced the subject and the speakers. *Dr. Wertham's* remarks in extended form appeared in the *Saturday Review of Literature*, March 29, 1948.

and only gradually concerned itself with the mental hygiene problems outside. In the same way psychotherapy was originally confined to the consultation room and is only now beginning to overcome its own claustrophilia and take an interest in the social influences that come to bear on the individual. It is, therefore, in the best scientific tradition to consider a social phenomenon so enormously widespread as comic books. The idea of this symposium originated in researches first carried out by the Lafargue Clinic.

This is the first exhibition of comic books. You see here examples of about one-third of all the comic book titles. This is also the first report on scientific research about comic books which is not under the auspices of the comic book industry itself. It was carried out in clinics, in schools and in private practice.

THE COMIC BOOKS AND THE PUBLIC

GERSON LEGMAN

New York, N. Y.

The aggressive content of comic books is so conspicuous that most people fail to notice that this aggression is rigidly channeled, that the willingness of any reader to accept a fantasy escape from his frustrations presupposes a willingness to achieve something less than total and actual escape.

The comic books concentrate on aggressions which are impossible under civilized restraints—with fists, guns, torture, killing, and blood. The internalized censorship of both artist and child makes this attack respectable by directing it against some scapegoat criminal or wild animal, or even against some natural law-like gravity, rather than against the parents, teachers, and policemen who are the real sources of the child's frustration and therefore the real objects of his aggression. At the same unconscious level that the child identifies himself with the heroic avenger, he may also identify whoever has been frustrating him with the corpse.

Violence displaced in this way from its intended object invariably appears in larger and larger doses, more and more often repeated. Twelve years ago, in 1936, there was not one comic book published in the United States. Today, at a conservative estimate, there are five hundred million yearly. The secret of this unprecedented success—the greatest, fastest literary success the world has

ever seen—is, of course, violence. All comic books without exception are principally, if not wholly devoted to violence.

The price being only a few cents apiece, and the distribution national, every city child can, and does, read from ten to a dozen of these pamphlets monthly, an unknown number of times, and then trades them off for others. If there is only one violent picture per page—and there are usually more—every city child who was six years old in 1938 has by now absorbed an absolute minimum of eighteen thousand pictorial beatings, shootings, stranglings, blood-puddles, and torturings-to-death, from comic books alone. The fortification of this visual violence with similar aural violence over the radio daily, and both together in the movies on Saturday, must also be counted in. The effect—and there are those who think it has been a conscious intention—has been to raise up an entire generation of adolescents who have felt, thousands upon thousands of times, all the sensations and emotions of committing murder, except pulling the trigger. And toy guns—advertised in the back pages of the comics—have supplied that.

Disguises are still necessary. At the lowest age level the necessary violence is presented as taking place between little anthropomorphic animals; gouging, twisting, tearing, and mutilating one another—Disney style—to a running accompaniment of all the loud noises and broad swift motions enjoyed by, and forbidden to, small children.

About a fifth of all comic books today openly glorify crime, and even these have to take it all back in fatuous exhortations to law and order at the top of every page. Also, after every seven pages of glorious cop-killing and law-breaking, the outlaw or gangster must be shown, on page eight, full of bullet-holes and covered with blood. In other words, the Katzenjammer-Kid formula, but with killing instead of spanking as the punishment, since killing and not “naughtiness” was the crime. This teaches the reader that (CRIME—in big letters (and then in little letters underneath) “does not pay.”

When children get to be nine or ten, the necessary violence is given a quick coat of literary paint by the industry, and re-appears under the respectable camouflage of being “classic,” meaning that all the most violent children’s books of the last two centuries are condensed into eight-page picture-sequences, omitting every literary element but the rougher dialogue, and squeezing into fifty pic-

tures or less all the violent scenes that can be found anywhere in the three hundred or more pages of the original "classic." Or the manufacturers hire psychiatrists, educators, clergymen, quiz-kids, public-opinion pollsters; and under their supervision the comics become "educational," meaning that instead of fictional violence, real violence will be substituted. Alfred Nobel is made educational in eight pages of dynamite explosions, Florence Nightingale in eight pages of Crimean war horror, Louis Pasteur—this was a hard one—in eight pages of corpuscles killing germs. There are even Bible comics—eight pages of Jesus Christ flagellated, on the cross, dripping blood.

These "classic" and "educational" products accepted by educators and psychiatrists are immeasurably more harmful than the crime comics they intend to replace. The crime comic tells the child that murder is the act of a criminal, and that it will be punished. The educational comic tells him the opposite. It gives murder prestige. A military hero killed so many and so many men. (Go thou and do thou likewise.) Not only murder is no longer a crime and need not be punished; in the educational comic, murder is rewarded, murder is heroic.

It is this same ability to transcend all human laws—and be honored for doing so instead of punished—that makes the Superman formula so successful. All of Superman's violence being on the side of right, there is no necessity for any Katzenjammer-Kid punishment on the last page, and this obvious flimflam suffices to blind parents and teachers to the glaring fact that the Superman formula is essentially lynching.

Instead of teaching obedience to law, Superman glorifies the "right" of the individual to take that law into his own hands. Instead of being brave and fearless, Superman lives in continuous guilty terror, projecting outward in every direction his readers' inward aggression. In the ten-year effort to keep supplying sinister victims for Superman and his imitators to lynch, comic books have succeeded only in giving every American child a complete course in paranoid megalomania such as no German child ever had, a total conviction of the morality of force such as no Nazi could even aspire to.

Nor are the comic books lacking in any of the trappings of their Naziism. There is the same appeal to pagan gods for totally unearned powers; there is the same exploitation of magical insig-

nia; there is the same anti-intellectuality, not only in the worship of thick necks and ape-jaws, and in the stock characters of the "mad" scientist, but in actual propaganda strips showing whole hordes of sinister scientists about to enslave and destroy the world. There is of course the same anti-Semitism—the more sinister villains have Jewish noses—there is the same glorification of uniforms, riding-boots, and crushed caps; and there is the same undercurrent of homosexuality and sadomasochism.

It is the intention of the comic book industry, and its psychologists, to focus the attack on comic books, now gathering, against the sexual element in them. And this sexuality is to be discovered, not in the comics' stupendous dosage of sado-masochistic excitements, but in the female breast: the women in certain comic books, the complaint essentially deposes, have highly developed binocular bosoms, and run around in brassieres and panties. Now just what there is about even a woman's *unbrassiered* breast that would come as a surprise to even a nursing child is hard to say, but the really surprising thing is the hypocrisy that can look at all these hundreds of pictures in comic books showing half-naked women being tortured to death, and complain only that they're half naked. If they were being tortured to death with all their clothes on, that would be perfect for children.

Naturally this formula is not popular with girls. Granting all the masochistic excitement of terror, it is difficult to identify yourself with a corpse. And so there are a whole series of so-called 'teen-age comic books, specifically for girls, in which adolescent sexuality is achieved in sadistic disguise, without father-daughter incest, without petting, without even a single kiss; through a continuous humiliation of scare-crow fathers and transvestist boy-friends by ravishingly pretty girls.

The Supreme Court of the United States has just struck down the laws of half the states against these and similar forms of literary bloodlust.

It is necessary to be realistic. It is an open question whether the fixation on violence and death in mass-produced comic books is a substitution for a censored sexuality, or is, to a greater degree, intended to siphon off—upon human sacrifices and fantasy victims—the aggression felt by Americans, children and adults alike, against general social conditions by which and to which they allow themselves to be distorted. In either case the distorting element

is basic, and until we are prepared to come to grips with these basic repressions, any attack or mere escape mechanism like comic books must be futile.

AGGRESSION AND VIOLENCE IN FANTASY AND FACT

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When praising comic books all experts state that they provide an outlet for children's innate "aggressiveness." Where does the idea of a ubiquitous presence of aggressiveness stem from?

Freud's theory of the death instinct has invaded all papers on aggression whether or not the writer adheres to any one of the analytic schools or bases his research more on the behaviorist approach. A striking confusion exists even in the description of what Freud meant—varying from one author to the other. The conclusions, however, are similar wherever comic books are described, namely, that there exists something called "aggression" for which an outlet has to be provided—otherwise harm will come to society or the individual.

At about the time of the first world war Freud, stimulated by the horrors of war, began to be interested in the problem of death and aggression. Then he did not find it necessary to assume the existence of a death instinct. As he had done before, he based his elaborations on "two groups of primal instincts, the self-preservative or ego-instincts and the sexual instincts" (1).

Cruelty, as discussed by Freud, was first conceived as originating with the individual and being linked with the sex instinct. Based on the war, which showed the State to be capable of greater violence than the Individual, he found cruelty to be connected also with the instinct of self-preservation. He never further investigated this latter social aspect of cruelty and violence. Freud called upon the science of biology and developed his theory of the death instinct.

From then on all of Freud's theories are based on the assumption of two instincts: the death instinct and the life instinct. He postulates that the aggressive instinct needs an outlet at all times in the actions of individuals as well as of groups, and that it constitutes the most powerful obstacle to culture. He repeatedly

emphasizes that, unless an outlet is provided, the instinct is taken over by the superego which thus heightens its aggressiveness against the ego. This instinct also provides Freud's dynamic explanation of wars, discrimination, and all forms of cruelty and exploitation.

It is possible to write two papers on this problem—one based on the death instinct theory. Comic books play on this instinct alone. But it is questionable whether this instinct should be permitted to achieve gratification if we want society to function, and whether it might not be wiser to use the entire power of education for the strengthening of the life instinct and the blunting of its antagonist.

It would appear that if violence and suffering, individual and social, are but an expression of an innate instinct, they are also inevitable, and any attempt to prevent them seems useless. Freud's pre-death-instinct theories provide a more fertile soil for research and a much brighter outlook for the future. I feel that the Freud who described conscience as "dread of the community and nothing else" (2) can better help us to get at the root of the problem of violence. I choose to base my thoughts on the assumption of two groups of instincts, the instincts of self-preservation and of sex, that is, of hunger and of love.

There are experiments pointing to a connection between frustration and aggression. Most workers in this field proceed from this assumption pointing out that aggression occurs wherever there is thwarting of an instinct. There is no unanimity as to the nature of instincts, and there is confusion also in the definition of aggression. Aggressiveness, aggressive acts, cruelty, sadism are used synonymously. Clarity can only be achieved with proper classification.

We must distinguish between action and the psychological soil from which action emerges. What is commonly termed "aggression" is a state of readiness to commit an act of cruelty, that is an act intended to cause pain in others and/or oneself. Where does this readiness to commit acts of cruelty or, to use a term coined by Dr. Wertham, this "free-floating hostility" come from?

We can assume that it occurs on the basis of frustration, that is, when we are unable to do what we want to do. Frustration creates a conflict—this conflict leads to tension seeking release in action against the frustrating force. The primary aim of reaction to frustration is to overcome the obstacle so that we may be able to do what we want to do. Destruction and pain which may occur

during this process are not the primary aims. To experience joy in destruction and pain alone, and not in attainment of the goal, is a sign of illness in either the individual or society.

The sources of frustration are twofold, stemming either from persons we know or from the (anonymous) society: one is connected with the singular individual and his immediate environment; the other, appearing more remote, with the plural, with society.

Without thwarting of direct gratification of a child's drives there can be no growth, that is no growing into any society. The genius of Freud has traced this necessary transformation of drives through the different stages from infancy and childhood to maturity. He has shown how the power for sublimation develops on the basis of the Oedipus situation via the different stages of narcissism with the help of the superego. From the beginning of life the child has to be inhibited from carrying out many wishes—he would not survive otherwise. Frustration is necessary for the child's protection as well as for the security of others.

Observations have been made showing that it is beneficial to encourage small children in acting out to a certain extent their feelings of hostility created by the thwarting of their instincts. What children seek primarily, though, is love and achievement and not destruction. They have to learn through experience and identification what pain is and how it is inflicted, and that their originally investigative destructiveness may make construction impossible. The wisdom of education consists in helping pave the way for sublimation which is the basis of civilization, and also in providing outlets for the gratification of instinctual desires. This is how anxiety and hostility can be kept at a minimum.

The advocates of comic books are unanimous in saying that there is an aggression *inside* the children which has to be brought out—none mention that aggression may be something the children are confronted with, something which is carried into them. Anna Freud states as follows: "In actual life it is as a rule, far more important to protect the child from the father's anger than the father from the child's hostility" (3).

A socially caused frustration is also a potent source of free-floating hostility in children. Children live in a hostile world, indeed. In our country, a country which has not suffered from the ravages of war, a recent survey showed that one out of every

ten school-age youngsters is physically underfed. And not only Wright's *Black Boy* (4) but many other youngsters have to take a stick when they go out on the street, not as a symbol of their masculinity but for the protection of their lives.

Thwarted action can be channelled in different ways: the child can, *in his fantasy*, create a world which permits him to do the things he wants to but is unable to do in reality.

Fantasy-making is a normal process in the development of children. It is particularly vivid and intense during the pre-puberty period, the age when comic books are read most prolifically. This is a time when there occurs an intensification of the sex drive and, at the same time, the process of dissolving of the Oedipus situation goes on more rapidly. The incorporation of the parental values, that is, the formation of the superego, has been accomplished to a large extent, and the child is now in need of an ego ideal which, as a rule, is sought outside the family. The child wants to and must assert himself as a person inside the family and, to a certain degree even against it. At the same time, he has to assert himself in society and here, too, largely against it. He longs to be taken into a group, to identify with it. He needs this for the purpose of strengthening of his ego as well as for his own protection and, furthermore he needs it for the development of his conscience.

In our individualized society he rarely finds this ideal setup, and so he has to fight for himself. This is quite impossible without a flight into fantasy and day-dreaming. What he seeks is release from tension, acceptance and happiness. The energy for fantasy is largely provided by thwarted action; fantasy, on the other hand, is stimulated by some current impression capable of arousing an intense desire. From there the mind wanders back to a time when this desire was fulfilled, and then the image of fulfillment of the wish is projected into the future.

When asked about comic books, the children without exception state that they select one picture, look at it for a long time, and "imagine that it is real." As Alex, age 12, one of my patients at the Lafargue Clinic, expressed it: "I look at them hard and keep looking at them. Every time I look at a picture I imagine I am in it. Every time someone gets hurt or shot I can feel that in the place where the person gets hurt or shot at. . . . And I feel also like I have the gun in my hand and pull it and it jacks when I shoot. I feel both at the same time. I always like to play it, too,

make believe I am the crook, sometimes I play the cop—but I do more of the shooting. I try to play it exactly the way it is in the comic book. My sister plays an actress getting captured. We make her walk on the street, then we catch her, take her to the basement, tie her up. Then we sit at the table and make plans how to get rid of her. In the meantime she is trying to escape.”

I have selected this one case for it is characteristic of the responses we found in the children we examined. The scenes used by children are all similar, they actually have no choice. Thus day-dreams and plays are stimulated, all of which have as their content violence. This violence is not a true reflection of the one children are confronted with in their daily lives. Comic book violence is individualized and highly specialized. People are being hurt in all sorts of ways, with all sorts of weapons and in all sorts of settings.

Children's fantasies, stimulated by comic book pictures, make them imagine violence as *the only way out*. For even as the “good” conquers the “evil” it does so by violence only. No one ever lives happily ever after.—Alex turns the page and knows there will be a new story with the same people solving the same problems by slightly varied methods of direct and bloody violence.

Children also find ample material for sex fantasies. And here another serious misdirection of their fantasy lives and actions occurs. Science has shown that sexual realism is important for healthy development of children. For, as Freud first pointed out, delayed training of the sexual instincts in the observance of reality predisposes to neurosis. If we assume that sexual aberrations, such as sadism and masochism, are symptoms of immaturity and expressions of a fixation on a very early childhood level, then the mass exhibition of such scenes is particularly bad for children.

Let us assume that Freud is correct in his theory that each child has to go through stages of development which include something like sadism and masochism, before he can be oriented toward enjoyment of sexual pleasure through the organs of sex proper, and also that these infantile stages have to be repressed if maturity and normal functioning are to be achieved. Comic book pictures with their repetition of sado-masochistic scenes constantly bring to the fore this repressed material and thus work against a healthy character development.

Where is the advanced concept of femininity elaborated upon

by the experts? Most comic book women are "phallic" holding weapons ready for use not only in defense but also for attack,—a picture giving rise to or confirming remnants of castration fears in boys. It is well known that this "phallic" concept of women is thought by Freud to be traumatic and a possible cause for the development of neurosis. Added to this is that women are portrayed either in typical sadistic or masochistic attitudes.

I have made a distinction between cruelty and sadism. We can formulate it in saying that cruelty is aggression connected with the ego instinct, whereas sadism is aggression connected with the sex instinct. The violent acts shown in comic books are all linked with sex. I mean to say, that the free-floating hostility, present in most children of our society, in the comic book stories and pictures appears transformed into aggressive acts which are linked with sex, and the female sex at that.

Children do carry out their fantasies. Our case demonstrates this very well. The road from day-dream to action is much shorter in children than in adults. One reason is that their fantasies are more vivid and life-like. This may be connected with the far greater frequency of eidetic disposition in childhood which disappears after puberty (5).

The child in his normal development has to test reality constantly. This is his most important way of finding out about the world. Children at the age when they read comic books are particularly prone to testing and experimenting, for they have begun to be suspicious of adults, to doubt the truth of what they are told, of what is printed in their books. We must not forget that comic books are produced by adults, and children know this very well. This doubt is a part of the process of self-assertion and freeing from parental authority described above.

The setting in which comic books fit into the causation of crime can best be expressed with the following quotation from *Dark Legend* (6): "It seems to me just as inexact to say fiction has no influence at all on people's actions as to blame crime on such fiction. Apparently anti-social impulses do not originate in that way. But when they once exist, added impetus may be given them by way of identification with a fictional scene." Our case shows clearly that children do identify themselves with the comic book characters—all of them: the "good" and the "bad."

It has been claimed that comic books help children solve their

problems. To be inspired to a play of strangling girls or killing boys seems a poor solution to the indeed pressing problems of children. Children ought to be given a chance to grow to maturity happily, to find gratification and to achieve sublimation. Comic books do not make this task easier for them.

BIBLIOGRAPHY

1. Freud, S.: *Instincts and their Vicissitudes*, p. 67. Collected Papers, vol. 4, Hogarth Press and Institute of Psychoanalysis, London, 1946.
2. Freud, S.: *Thoughts for the Times on War and Death*, p. 294. Collected Papers, vol. 4, Hogarth Press and Institute of Psychoanalysis, London, 1946.
3. Freud, Anna: *Psychoanalysis for Teachers and Parents*, p. 42. Emerson Books, New York, 1935.
4. Wright, Richard: *Black Boy*, p. 15. Harpers, New York, 1945.
5. Wertham, F.: Eidetic Phenomena and Psychopathology, *Archives of Neurology and Psychiatry*, October, 1930, vol. 24, pp. 809-821.
6. Wertham, F.: *Dark Legend*, p. 200, Duell, Sloane and Pearce, New York, 1941.

THE CHILD'S CONFLICT ABOUT COMIC BOOKS

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At the outset I would like to say that, when Dr. Wertham asked me to join the Symposium on the "Psychopathology of Comic Books," he made it clear that this suggestive title should by no means color the point of view of this study. Perhaps I might find something to the contrary of psychopathology. Instead of making a deductive study, I decided to find out from children directly what their reactions were to comic books.¹ While this project was under way I learned of an evaluation of comic books made by 230 students of a college in California.² This evaluation represents additional material that has been supplementary and corroborative of the findings of the data I have obtained from the children. Now, after all these data have been collected, scored and evaluated, they reveal material that is less than that on pleasure books.³

* With the assistance of Gertrude Resek, Community Service Society of New York.

¹ I wish to express my thanks to Miss Clare Dewsnap, Principal of Germantown Friends Lower School, and to Dr. William E. Burkard, District Superintendent, Board of Public Education, Philadelphia, Pa., for their help and interest in my obtaining the data of the following study.

² I am indebted for the material of the college students to Dr. John Otto Reinemann, Director of Probation, Municipal Court of Philadelphia, Pa.

³ The designation "pleasure books" refers to any reading other than comics.

In this study, eighty white and Negro children, boys and girls between eleven and twelve years of age, were made the subjects of an inquiry on the topic of comic books. Their school teachers put six questions on the black-board and asked the children to write down the answers. They were told that unless they answered these questions truthfully, there was no sense in answering them at all. They were also told that they did not have to sign their names if they did not want to.

These were the questions:

1. How much time do you spend per week on comics? Is this more or less than on pleasure books?³
2. What kinds of comics do you like? Why? What kinds of comics do you not like? Why?
3. Do you prefer pleasure books or comics?
4. What are the best things about comics?
5. What are the worst things about comics?
6. Do you think parents and teachers should encourage or discourage you in reading comics?

Here are some of the results of the children's reactions to these questions. All the children spend some time on comics. It varies from what they called "very little" to 15 hours a week. Out of the 80 children only 18 admittedly prefer comics to pleasure books; 57 children prefer pleasure books; and five cannot decide. 16 children feel that parents and teachers should encourage children to read comics; 37 suggest discouragement, and 25 are undecided. The "best things" about comics, according to the children, are the pictures, the excitement, and that comics are "funny"; the worst things about them are: murder, crime, that they are misleading and tempting, and that they put bad things in your mind.

The most interesting feature in these responses is the fact that, out of the 18 children who prefer comics to pleasure books, 9 children feel that reading comics should be discouraged. Such inconsistency definitely points to a conflict, a conflict that can be found in many more responses though not as obviously as in these nine cases. Five of the nine children list crime, murder, and bad influence as the "worst things" in comics, and since these children prefer the reading of the comics to the reading of pleasure books and yet would like to be discouraged from reading comics, they must feel threatened by, at least, these "worst things." Perhaps they find pleasure in being threatened, which means in this case being drawn toward their primitive impulses. But as soon as they are confronted with the rational question, as to whether they want to have more of this kind of "pleasure," they seem to feel guilty and would rather be protected from it.

But before going into the content of the conflict that the children have expressed, it is worth our while to look at the evaluation of the comics made

by the college students which I mentioned before. This evaluation represents in the form of an abstract the opinion of 230 students on 74 popular comics. These comics are equally divided in two groups; (1) the objectionable, (2) the unobjectionable kind. There are 37 in each group; but among the objectionable kind there are still quite a number which are characterized as "mildly objectionable" or even "very definitely objectionable" if they were given to children. Now with regard to the findings about our 80 school children it was striking to see that the 230 college students have characterized 18 comics out of 37 as "*motivating dangerous imitation*." The number 18 refers only to those evaluations where the definite statement "*motivating dangerous imitation*" had been made, although each evaluation of the objectionable kind implies the "danger of imitation." The students, either through empathy with the imaginary reader or through memory of their own reactions, have put their fingers on the same point which is a crucial one: imitation.

What does imitation mean?

Imitation is a mimicry reaction. It is one of the most primitive expressions of man's need for protection. If he is different, distinguishable, he will be "discovered" by his "enemy." But if he is like the others, if he wears a uniform, he feels safe, secure. It is a sign of maturity if one can relinquish the uniform, or his gang, or his tribe, and afford to be distinguishable, an individual in his own right. But such maturity cannot be expected of children. In fact, for them the desire to be like the others, to herd or to gang, hence the aping and imitating, is perfectly normal.⁴ But here the question arises: whom and what do they imitate? They imitate each other—certainly the uniform pattern of comics-reading can partly be explained through imitation—they imitate their parents and teachers, and those whom they want to be like. By and large, they want to be like those who are in authority, who have "the power." They want to be like those whom they are attached to in love, in fear, in hate. Imitation is the outer act of the inner defense mechanism "identification." And it is this inner defense mechanism about which the children are concerned and which is the content of their conflict.

The process of identification and its role in the formation of the ego and the superego has been widely explored in psychoanalytic literature, in the works of Freud, Federn, Fenichel, Deutsch, Aichhorn, and others. To go more fully into these explorations, or interpretations, would require a study in itself. Therefore it cannot be done here. But there is one concept that has grown out of these explorations, a concept we cannot dispense with, since it is basic to our understanding of the peculiar conflict the child

⁴ The term "normal" is used here as a statistical concept, distinguished from the teleological or idealistic concept of norm (cf. Edmund Mayer, "Zellschädigung und Mitose," Virchow's Archiv 1930, vol. 275, pp. 114-134).

dren seem to be caught in, in relation to the effects of comic books: it is the concept of the *identification with the aggressor*.

Whereas identification with a beloved person has a socially desirable, constructive function in the child's mastery of his instincts, under certain circumstances identification appears in a perverted fashion, as it were, causing the child to side with objects or persons which threaten him. Anna Freud has pointed out that identification with the aggressor, or with aggression itself, impersonation into a person that is a threat to the child, is one of the most natural and widespread modes of behavior on the part of the primitive ego and has long been familiar to those who have made a study of primitive methods of invoking and exorcising spirits and of primitive religious ceremonies.⁵ A child introjects some characteristics of an anxiety-object and so assimilates an anxiety experience which he has just undergone. The child's conversion from the person who has been threatened into the person who makes the threat is accompanied by the experience of a deep conflict. One aspect of this conflict is related to the assimilation of the anxiety-object as a source of release and pleasure and the awareness that such assimilation represents a "bad," that is a socially unacceptable, act. This act therefore is being felt, or registered, by the child with guilt.⁶

If we now look at our data in terms of the child's defense mechanism of identification in general and of identification with the aggressor in particular, and the experience of conflict that is inherent in that identification, we see the children's responses to the questions about comics in a new light. It is an inherent characteristic of any conflict-situation that it exerts fascination over the individual through the pull in two divergent directions. Being pulled in two directions is being trapped, paralyzed. One cannot decide. Everything is in suspense. There is an everlasting excitement going on about what way to turn—if any. It is a highly conflicting, an ambivalent excitement, an admixture of lustful pleasure and guilt that arouses the children who identify themselves with aggressive forces of the type they are being exposed to in the comics. This excitement is of the most primitive kind. Educational guidance of the child's ego aims at protecting him from his own primitive impulses. But these very impulses are stimulated and appealed to in such excitement.

Appeal to primitiveness is the effect that is at the basis of the influence comic books have on children. The child's primitive impulses, instead of being gradually transformed into socially desirable behavior and attitudes, are constantly being stirred up. These attacks, however, are made not from one side only. They are made in the disguise of "content" as well as in the disguise of "form." Whereas the conflict of identification with the

⁵ Anna Freud: "The Ego and the Mechanisms of Defense," p. 119.

⁶ The defense mechanism of the ego that is at work here is a rather complicated one. See Anna Freud, *loc. cit.*, p. 128.

rather doubtful "heroes" of the comic plot refers to the *content* of the child's experience, there is an experience related to the *form* of the presentation. Form is expressed, for example, by means of language. But what kind of language is the language in comic books? If one would make a study of the semantics of comics or of their style, one would probably find that their language, as far as there is any, expresses crudest primitivity. Actually, however, comic books are picture books. They are written in picture language rather than in word language. Expression and communication through pictures is older and even more primitive than expression and communication through word language. The reading of picture language must instigate thinking in pictures which, according to Freud, "is only a very incomplete form of becoming conscious. . . . It approximates more closely to unconscious processes." Approximation to unconscious processes means appealing to the child's primitive impulses. If we would carry this consideration further and evaluate the contents of the pictures as well as of the word language, with regard to their effect on the child, we would realize that either of these form expressions must be both attractive and repulsive to him. It is well known that children indulge in "bad" language and yet are repelled by it, particularly during latency. The same must be true of the children's reactions to the utterly crude, violent, and, frequently, sexually stimulating "picture language" of the comics. Again and again the child is exposed to conflict. Different methods aim at the same goal, the goal of primitivation, enhancing vice-versa their fascination over the child.

THE PRACTICAL ASPECTS OF THE BAD INFLUENCE OF COMIC BOOKS

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The term comics is a serious misnomer. The modern comic is indeed a far cry from its prototype, the humorous parodies on human behavior and situations, which are still seen in some of the newspaper cartoon strips. The vicious monthly magazine type publications which flood the local newsstands and neighborhood candy stores and hit tremendous sales records have great appeal to a certain type of adult as well as to children.

The child and, even more so, the young adolescent living in the penumbra of an adult world of half-revealed secrets of life, and half-understood causes and results of violence, war and crime, have their curiosity whetted by the plots and pictures in comic books. Comic books, furthermore, awaken the sado-masochism which lies dormant in children.

Where does the harm exist in such outlets? Let me briefly indicate that to you from my clinical experience as a child psychiatrist. First of

all, while a child's natural curiosity should not be curbed, it need not be whetted. A child's questions should be encouraged by parents and teachers by inspiring confidence in the child. These should be answered within the ability of the child to comprehend, and the scope of the answer should frequently be limited to the scope of the question. Comic books raise conflicts and disturbances in the child's mind which they answer in false and often terrifying fashion.

The child, no less than the adult, is influenced by the printed word, and especially the printed picture. Thus, he experiments in thought—and what I want to emphasize especially—in action with the violence he sees in the comics. There are rather frequent newspaper accounts of brutal slayings of children by their playmates, many accomplished in comic book fashion with binding, beating and torture, and with little or no motive.

Just as with justice triumphant over crime, the comics smother violence with more violence, so when they attempt to battle social prejudices their emphasis and appealing sadism is so strong that the triumph of right at the end is a weak anticlimax.

Well-adjusted children with adequate satisfaction and outlet for their emotions may perhaps less easily become absorbed with comics, but even they cannot help being influenced and harmed by them. Today, with our increased pace and tensions of living, the juvenile group of the population is rapidly becoming infected with the neuroses of its adult "rulers." It is this ever-increasing number of neurotic and emotionally deprived children who are the prolific comic readers, and who are most suggestible to the bad influence of these publications. The comics are an ill wind which blows good for the publishers. This unfortunately still proves to be a stronger argument than the welfare of the public.

DISCUSSION

Johann G. Auerbach, M. D.: The "training" of the child, is a training to conformity. Only to the extent to which the wishes of the child coincide with those of society, are they allowed expression. This training involves suppression and frustration, reason enough for the development of aggressive trends!

At an early age the child is made to learn that he ought to control sexual desire and hostile feelings. The means by which he is taught this are altogether punitive, consisting in corporal or mental punishments, withholding of desirable objects or of love. The child has no choice in the matter. If he does not want to incur punishment, he must refrain from sexual activity, and from aggression against his educators.

Thus a need is seen for some permissible outlet for the forbidden tendencies. The question is, do bloodthirsty and sexy books provide such a harmless outlet? Do they by their appeal to the fantasy of the child

prevent him either from living out these trends in reality, or from becoming neurotic through repression? Is the fantasy the right locale in which undesirable desires should be "worked out?"

The answer is that such a representation of the function of comic books demonstrates a complete misunderstanding of repression, neurosis, and the analytic approach from which these terms derive.

Our objections are:

1. There is little left to the fantasy by the over-realistic presentations of cruelty and sex (and their combination) in comic books, other than the easy task of substituting the heroes and victims in the books by persons in the child's environment, including himself.

2. Instead of "satisfying" the undesirable impulses, instead of giving them a substitute outlet, they only stimulate the desire to translate fantasy into reality. I wonder if a woman on a reducing diet likes to leaf through her cookbook, hear about meals in fine restaurants, stand in front of window displays of her favorite delicacies, in order to find a fantasy-outlet for her food cravings?

Or to put it another way, if our adult repressed aggressive tendencies could be assuaged by constant talk of war, atomic weapons, bacillary bombs.

Stirring up the fantasy to cruelty and sex can never be considered an outlet; it never does away with them even temporarily, because the last stone in the structure is missing, namely, real life experience. Looking at turkey will not satisfy hunger, and looking at partly naked girls will not satisfy sexual desires.

What then about fairy tales, and their illustrations? Why does the picture of Hansel and Gretel pushing the witch into the oven create no desire in the child for vindictive action against those who boss *him*? How does the bloody cutting open of the wolf's belly to let out Red Riding Hood's Grandma differ from the knife attacks depicted in the comic books? Why do fairy tales help the child to get rid of his feelings of aggression, when comic books obviously fail?

I believe the answer lies in the fantastic element of the fairy tale, which depicts a world far removed from reality. The child may identify himself with the persons or animals in this fantasy world, which he makes his own. There he may allow his fantasy to soar as he wishes: it is his private empire in which *he* reigns. He knows the difference between the real and the imaginary; there is no attempt to bridge the gap.

Another helpful characteristic of fairy tales is their poetic form, even in prose, which also tends to remove tragedy or mischief from everyday life. (For instance, Mother Goose.) The less fairy tales obey these two laws, the more they are apt to instil in the child anxiety, or a desire to translate fantasy into reality. Unfortunately, for the neurotic child the fairy tale provides the danger of escape. But it is only the child who is

not equal to the pressure of his environment who will take advantage of the opportunity to all but retire to a fairy tale world.

Dr. Wertham has emphasized that violence in juvenile delinquency has increased in direct proportion with the spread of comic books among the youth of this country. We have offered one possible explanation of this phenomenon. If aggressive trends are undesirable, there should first be the greatest possible elimination of authoritative demands on our children. In their place, we should offer love and increasing cooperation, thereby reducing the *causes* for hostility. If there is little cruelty in the handling of our children, there will be little need for their revenge and aggression.

Furthermore, if our society feels that it cannot tolerate early activity, the least it can do is to protect the child from sexual stimulation. What a diabolic practice, to permit the child to be actively stimulated by comic books and then to punish the child for succumbing to the constant temptations thrown in his face.

Surely the SPCA would bring a person to court who made a practice of letting a pet go hungry, then putting his food in front of him, only to punish him if he ate it. The Pavlov experiments proved that hunger is stimulated by the show of food. In the same way, aggression and sexual desire are stimulated by the presentation of such comic book pictures.

Aggression can largely be eliminated by careful educational methods. Whatever is left of it through the inevitable frustrations of culture should be allowed to be expressed directly in real, if mitigated, civilized forms.

Mr. Charles Biro, an editor of comic books, stated vigorously that comic books are getting better.

Mr. Alden Getz and *Mr. Harvey Kurtzman* suggested that comic books should be improved and made educational.

Dr. Augusta Jellinek discussed comic books from the point of view of reading and denied that it was possible to "make comic books educational."

Mr. Harold Straubing, Comics Editor, *New York Herald-Tribune*, defended comic books. "Whether the responsibility for a delinquency rests with the comic book influences is doubtful, because we are exposed to so much crime, violence, conflicting ideas and social problems in life and other mediums of expression."

Mr. Albert Edwards discussed comic books and the problems they present in reformatories. He stated that some supervisors resorted to comic books just to keep the boys quiet. He had observed that "when it came to drawing, the boys drew pictures from the comic books that showed violence or a preoccupation with unhealthy sexual attitudes."

Mrs. Edward Flemming, *Mr. Alfred Feingold*, *Mr. Henry Bark* and *Mr. Charles W. Collins* also participated in the discussion.

CURRENT LITERATURE

BOOK REVIEWS

WINFRED OVERHOLSER AND W. V. RICHMOND. *Handbook of Psychiatry*. Lippincott Company, 1947, 252 pp., \$4.00.

At a time when the layman in his drive for a better understanding of psychological problems, is easily misled by incompetent popular books, by sensational movies and distorted press reports, the edition of a handbook which rests on a sound basis and is written in part by so outstanding a psychiatrist as Overholser, is a laudible task. The book is destined "for the college student, the nurse, the average man and woman who has mentally ill relatives or friends," and its purpose, according to the editor, is "to clear the fog of misconceptions surrounding psychiatry."

The character of this handbook is not different from that of a brief textbook of descriptive clinical psychiatry, books which are sometimes worth to be read even by psychiatrists. The reviewer feels, however, doubtful whether the current handbook will satisfy the needs of a wider circle of lay readers. Very little space has been given to the dynamic and the psychoanalytical viewpoint, and the case histories in most chapters are too brief to serve their purpose. It appears that the sincere and anxious desire to be factual and scientific induced the authors to write this book in a rather academic and clinical fashion. Its appeal to the layman, therefore, may prove to be limited. Also the lack of pictorial material diminishes, in the reviewer's opinion, the value of the book which is intended to give enlightenment to the layman.

The handbook deals with the position of psychiatry within the realm of psychology, with the causes of psychosis, with the general principles of treatment, and with the services rendered by mental institutions. In a series of chapters the authors give a clinical description and classification of psychosis.

Psychoneuroses should have received a longer presentation owing to their central position in psychiatry and their importance in our time. To the revolutionary contribution which psychoanalysis has made toward the understanding and therapy of neuroses not more than two pages have been devoted. Excellent are the chapters dealing with alcoholism, psychopathic personality, criminology, military psychiatry and psychiatric disorders in childhood.

MAX FRIEDEMANN, M. D.

ROSE H. ALSCHULER, AND HATTWICK, LA BERTA WEISS: *Painting and Personality, A Study of Young Children*. Two volumes, The University of Chicago Press, Chicago, Illinois, 590 pp., \$10.

This study is concerned with children's self-expression in play and free art work. Through various media: paints, crayon, clay, blocks, dramatics, the children's expressions are studied and related to behavior and life situations at home and in school, as well as to the child's normal growth or its deviation. (Unfortunately, the concept of "norm" as it has been employed in this study has nowhere been defined.) During the course of their investigations the authors were led to focus their interest more specifically on easel painting since this activity had proved to them to be a much preferred form of self-expression in young nursery school children.

One hundred and seventy "normal" children from eight different nursery schools, 88 boys and 82 girls between the ages of two and a half and five and a half years, were the subjects of this study. 149 of them were observed daily for one year, 21 for two years. The authors avoided limiting their study to a too highly selected group by choosing the children from socio-economic backgrounds that ranged from wealthy to underprivileged families, including Negroes and persons from a needy foreign-born community.

Since this is the first extensive color study on children's paintings, certain aspects with regard to the use of color in preschool children have come to the fore that are very interesting and might eventually become diagnostically helpful. Painstaking effort has been exerted in going into all the possible details and versions in analyzing the children's products, and the studies have been abundantly illustrated with color plates. A great many single data have been secured based on observations of a wide range. These efforts in themselves may stimulate teachers and clinicians to further investigations.

But if one considers this work as an entity, it has hardly passed the state of the raw material which it presents so generously. The single data have not been integrated into a whole. All of the parts are there, but the binding ingredient is lacking. Usually this ingredient is furnished through a satisfactory methodical approach. In the case of this comprehensive study it must have been extremely difficult, if not impossible, to find an appropriate method that would deal effectively with data that are not only enormous in quantity and secured from too great a variety of necessarily uncontrolled sources, but that are heterogeneous in themselves. The great devotion that has been given to the individual child has eventually resulted in statistics. The authors have realized themselves that statistical treatment—indispensable as it is for certain research projects, and to some extent for this study—will not yield insight into the individual case about which they have been so concerned. The great devotion that has been given

to the children's individual products has resulted in a conscientiously thorough, but piecemeal and "static" analysis of their paintings which have been examined as to their color, form, space, etc., values. Nowhere have these values, or aspects, been drawn together, or been related to the product as a whole, as an organism with its configurational and emotional significance. It seems to me that an understanding of a child's painting as to its psychological dynamics can only be achieved if we leave behind the preceding analytical stage, although relying on it, and let the child's picture act upon us as a unique entity eloquent through its expressive movements.

There is another methodological pitfall that, I feel, could be avoided in similar projects. It concerns the personality inventory that has been employed in this study to record the children's behavior characteristics. This inventory mixes external and internal factors, objective and subjective ones. There is no differentiation between a statement as complex as "reaction of the environment toward the child," or even "adjustment in general," and recordings as specific as "the child wants to name his product." These statements are evaluated on the same level, as though they had equal weight. In setting up a personality inventory, the data that are to be coordinated should be treated with such discrimination that, topographically, they could be related to the same psychological stratum.

In the preceding paragraphs this reviewer has been concerned chiefly with the method used in the work of Alschuler and Hattwick, and has been rather critical on that score. Nevertheless, it must be emphasized that the material and data collected during these studies are extremely interesting and will be of great value to persons working in this field.

PAULA ELKISCH, PH.D.

Philadelphia, Pa.

DETROIT MURDERS, edited by Alvin C. Hamer, Duell, Sloan & Pearce, N. Y., 1948, 218 pp., \$3.00.

This is a book in the Regional Murder Series comprising volumes on true murder cases in New York, Chicago, Denver, San Francisco, Los Angeles, Cleveland, and Charleston.

The volume on Detroit is perhaps more rewarding as a book on Americana than on murders. The most interesting is a murder case of 1889 called "The Dog in the Night" by Anna Mary Wells, the title coming from the dog that did not bark.

Murder cases are important raw material for psychiatric study. Unfortunately, the division of work is such that the writers who give the best descriptions of such cases know little about psychiatry, and the psychiatrists and psychoanalysts who make big generalizations about violence and murder have never examined a murderer with even a fraction of the time they bestow on a patient with a handwashing compulsion.

"The Dog in the Night" deals with a matricide which in many ways conforms to the pattern laid out in the only existing study of matricide, *Dark Legend*. His age fits (he was twenty-three), as well as the fact that the murder was committed in the mother's bedroom. At the time the case was investigated and tried, no attempt at psychological understanding was made: "Neither the defense nor the prosecution ever suggested that there could be any doubt of Irving's complete sanity and responsibility." When he left town after the murder he gave his employee in the store the "easily disproved excuse" that he had "to act as a pallbearer at a funeral." During the investigation little of his previous life was brought out. He said of himself: "I never have been able to shed tears, even when I was a small child and badly hurt." He spent many years in jail (where, towards the end, he subscribed to the magazine *Mental Hygiene*. At the age of seventy-five, after he had been free for some years, he was declared insane and sent to a state hospital.

We may look with disdain at the unpsychiatric handling of such a case seventy years ago. But that is false pride. Most of these cases are handled in the same way today, even though occasionally some Latin or Greek terms may be introduced.

FREDERIC WERTHAM, M.D.

New York, N. Y.

EMIL FROESCHELS: *The Human Race, a Study on the Nature of Knowledge*, Philosophical Library, New York, 1947, 197 pp., \$3.00.

Froeschels who has gained a world-wide reputation by his work on speech disorders has also written and lectured for decades on the subject of "Medicine and Philosophy." This reviewer is not competent to appraise the value of Froeschels' ideas on pure philosophy. Seen from the viewpoint of a neuropsychiatrist, however, they seem interesting and stimulating even when they arouse opposition.

The basic concept of the author is that of "congenital knowledge" which man has of the infinite, God and the universe. The concept of any congenital knowledge is difficult to grasp for a modern psychiatrist and this reviewer felt relieved when toward the end of the book he met (on page 178) with the expression "latent" knowledge and (on page 179) even "potential" knowledge. Froeschels discusses the mathematical, philosophical and religious aspect of the infinite; psychological or biological aspects are not discussed by the author who in turn complains that the significance of the infinite for the human mind is not grasped by the mathematicians. For Froeschels a personal God exists and when one logically removes the doubts about his existence, love for God develops in one's heart. He does not discuss the opposite aspect: where love or need for God exists the logical reasoning may follow suit. Of course, for the author monotheism could

not have developed from preceding polytheism. Few will argue with Froeschels when he attacks the idea of the Unconscious on philosophical basis and favors the term "subconscious." He furthermore proposes the substitution of the term "expression-ripe" for the Conscious and "non-expression-ripe" for the Subconscious. Expression-ripeness rests upon the act of identifying experiences with congenital knowledge. Training serves only to give a higher degree of confidence and reduce the resistance of the body to the will. Repression is: being avoided by the will. The unpleasant ideas are being "forgotten" because the will does not like them and does not want them to become expression-ripe again. The subjects which "have passed the stage of speech-ripeness" are stored in the Non-Expression-Ripe without being connected with a word. He assumes a "permanent knowledge" of everything once expressed. Later he states that the Non-Expression-Ripe contains subjects with adequate words and without them. Understanding leads to certain typical emotions: it leads from the expression-ripe toward the non-expression-ripe; it is an appeal to our congenital knowledge of the universe.

Much of the book is devoted to the various concepts of time, rest and motion, being and becoming, concepts and their relation to time, reason and will, metaphysics, life and after death. In discussing freedom of will, causalism and conditionalism he sees the will as making us perceive causes; to him causality is a category of will power and not a form of thinking. Conditionalism is a form of thinking. Similarity is a feeling not a form of thinking. In medicine some phenomena can be better described as causal, others as conditional. The first approach is more practical, the second more scientific; both are necessary. The will chooses freely among the motives; there are no stronger or weaker motives. The body is just an obstacle to the will. Psychogenic disturbances are a combination of normal soma and subnormal will; "psychogenic hyperkineses" the result of normal soma and oversized will. "True is everything that is thought of and believed as being stable and represented in reality.—Reality is the continually changing inner and outer world." Froeschels' philosophy based on the premise of "congenital knowledge" rules out, e. g., that man is a descendant of the line of animals, and is in strong opposition to any psychological determinism.

JOSEPH WILDER, M.D.

New York, N. Y.

HAMLET. Vision Press, London, 1948, 180 pp. 8s.6d. With an Introduction by Ernest Jones. Illustrated by F. Roberts Johnson.

A beautiful new edition of *Hamlet* has an introduction by Ernest Jones on "The Problem of Hamlet and the Oedipus Complex." The illustrations by F. Roberts Johnson, done in surrealist style, achieve a strange evoca-

tion of subconscious feelings. They have a distinctly contemporary character. Dr. Jones' essay, on the other hand, republished in substance from his article of 1911 and going back to much earlier suggestions made by Freud, is behind the times, with a typical blindness to scientific progress in analytic *Hamlet* criticism. The discovery of unconscious infantile attitudes as an explanation of *Hamlet* was a great advance when it was made—but that was a long time ago. Newer studies based on a closer examination of the text itself have unravelled the matricidal theme in *Hamlet* and demonstrated the close parallel between Hamlet and Orestes. These recent psychoanalytic insights, which the British literary critic G. W. Stonier only recently called "the most influential criticism since Bradley," invalidate Jones' summation and render his whole essay out of date.

FREDERIC WERTHAM, M.D.

New York, N. Y.

SAMUEL KAHN, GRACE KIRSTEN, AND MAY ELISH MARCH: *Practical Child Guidance and Mental Hygiene*, Meador Publ. Co., Boston, 1947, 285 pp., \$4.00.

This volume attempts a practical approach to the understanding and handling of childhood maladjustments. It is intended for "parents and friends of children" and is a collection of questions and answers covering a wide range of familiar home situations.

Each of the 24 chapters is introduced by a very brief presentation of fundamental principles which will have meaning only to those who already have a better than average insight into childhood problems. They do not, therefore, serve to clarify the questions and answers that immediately follow.

The explanations given as to the causes underlying difficult and non-acceptable activity by the child are likely to meet with considerably greater agreement than will the projected methods of correcting such behavior. The authors' recommendation for the use of repeated verbal suggestion reveal an unrealistic enthusiasm for the value of such an approach. For example, in Questions 1-15, "What should a parent do with a child who hates his teacher and hates school?"—the authors offer the following answer: "Tell him that, because you know his teacher and the school people love him and wish him well, he in turn is loyal and loves his teacher and school. Repeat this formula occasionally. . . . Tell him that you know he is a good student. . . . Be sure that there is nothing in the home that interferes with his schooling." (How will parents know where this type of "suggestion" ends and nagging and scolding begin?) There is a similar confidence in the effectiveness of whippings, threats of whippings, and in the ability of parents to administer same with a complete absence of anger and to "always appear to be stable emotionally" when using physical punishment.

Many of the problems for which "practical" and direct measures are outlined can be altered only by changes in family attitudes and would necessarily require much time and patience. The self-education of the parents should receive greater emphasis as too many parents will achieve little success in coping with these problems except insofar as they themselves are capable of change. Many of the particular situations presented reveal immaturity reactions which, if of long duration, will respond best to a decrease of home tensions and an increase in the child's sense of security. Too often, no amount of suggestion or physical punishment (as used in this publication) will provide a stimulus for growth without the existence of a springboard in the form of love and security.

The book contributes to the understanding of the causes of childhood behavior problems, but its usefulness as a guide for the successful management of these problems is very limited. Its psychological shortcomings will prevent its wide adoption by "parents and friends of children."

FRANK A. CASSINO, M.D.

Brooklyn, N. Y.

DOROTHY W. BARUCH: *Glass House of Prejudice*, William Morrow and Co., N. Y., 1946, 205 pp., \$2.50.

If one reads many psychiatric and psychoanalytic case histories one cannot fail to notice the absence of any proper evaluation of race hatred, prejudice, discrimination and segregation in the emotional development of the patient. And yet many years of careful analytic studies have convinced me that exposure to racial hatred from early childhood is in our historical epoch as important a pathogenic factor as sexual difficulties. Evidently this is an area where even the psychoanalyzed psychoanalyst keeps his own scotoma intact.

It is for this reason that a book like *Glass House of Prejudice* can be recommended to young psychiatrists who still have an open mind. It is a book full of facts and examples of instances of prejudice against all minorities in the United States. Los Angeles is taken as a typical city.

The author does not shrink from comparisons with Germany and states, "The startling thing is that the beginnings in Germany were psychologically not very different from what has been happening here." She summarizes the "minorities" in America as follows: 5,000,000 Mexicans; 13,000,000 Negroes; 5,000,000 Jews; 5,000,000 aliens; 500,000 American Indians; 127,000 Japanese; 77,500 Chinese; 45,500 Filipinos.

Despite the fact that it contains such good material, the book is not completely satisfactory as a whole, for the author does not sufficiently recognize that race prejudice is not just a neurotic aberration, but is motivated by powerful social and economic forces which can be understood only historically. She says "The hopeful thing is that today we have at

hand the psychological tools we need to conquer it." But psychological therapy or education of individuals for this important social problem is no more than an evasion of social responsibility. The psychiatric reader who wishes a more profound interpretation of the facts of Dorothy Baruch's book may be referred to "Caste, Class, Race, A Study in Social Dynamics" by Professor Oliver Cromwell Cox.

New York, N. Y.

FREDERIC WERTHAM, M.D.

EMILY HARVIN: *The Stubborn Wood*, Ziff-Davis, New York, 1948, 365 pp., \$3.00.

According to the publishers, the author is a "woman who survived two years in private asylums environed with the violently insane, often in solitary confinement, and frequently drugged." The novel deals with this phase of her life.

A novel can, of course, select its topic and its dramatic conflicts any place. But if the author or the publisher feels it necessary to stipulate that we are dealing with a true story, the aspect of the case changes. For the story claims nothing less than that the author (Monica in the story) was railroaded into mental institutions and that she was locked up for two years in two different sanitariums for the sole reason that her husband, who was "developing into an alcoholic and philanderer" wanted to have her out of his way.

In the first sanitarium Monica "was kept in a semidrugged state in order that the routine might run smoothly", while in the second place "the brilliant woman psychiatrist Dr. Wallace . . . chose to adhere to the heartless standards of professional loyalty and upheld the former doctor in his untruthful contentions . . . Monica was diagnosed as an insane malingerer." (Whatever that may be.)

According to the publisher, "it is a tribute to her courage and stamina that she never once ceased to fight for her freedom and that . . . she rated superior in I. Q. and aptitude tests . . ." (As though either of these factors excluded the existence of a paranoid psychosis.)

As such, the topic chosen by the author—life in an institution for the insane—can be extremely interesting, and can be dealt with in a tender, sympathetic way. Instead, this reviewer finds the novel elaborate, stilted, its involved action proceeding at a slow pace. The obvious intent to discover and expose the "conspiracy" of criminal, heartless physicians, authorities, nurses, and other groups deprives this book of its higher literary values.

The publisher informs us that the author is using a pen name because "she does not choose to bring public shame and scorn and perhaps financial ruin to those responsible for the shocking indignities and criminal neglect she suffered."

This reviewer disagrees; he feels that such gentle humanitarian consideration for the perpetrators of the hideous crimes described in the book appears grossly misplaced. If the book is eloquent enough to make one of its critics inquire, "Are we locking up the wrong people?", its author should have the courage to insist that the law-breakers among psychiatrists as well as among hospital personnel and among civic authorities be brought to trial and expelled from their public positions. Otherwise the book becomes an insignificant case history of an unbalanced person who among other things boasts that she was "the first female in a well-known and widely respected family to divorce a husband, wear slacks, smoke a cigarette or take a job."

EMIL A. GUTHEIL, M.D.

New York, N. Y.

LAURA W. FITZSIMMONS: *Textbook for Psychiatric Attendants*. Macmillan, New York, 1947, 332 pp., \$3.50.

The actual day-by-day and night-by-night treatment of mental patients in state hospitals is one of the Achilles heels of present-day American psychiatry. For that reason, a book concerned with the work of psychiatric attendants is very welcome.

This textbook can be recommended, provided that it is clearly understood that it serves merely as a basis for lectures and demonstrations and not for self-instruction. It is particularly commendable that the author points out the danger of restraint.

Where the author is a little unrealistic is when she describes simple concepts of mental hygiene for attendants in mental hospitals; e. g. "try to like everyone"; "cultivate a happy frame of mind," etc. Many attendants have to live and work under such difficult circumstances, under such indifferent superiors, and have to see sometimes such shocking conditions, that they will find it hard to follow these Pollyanna precepts.

FREDERIC WERTHAM, M.D.

New York, N. Y.

EPILEPSY—*Psychiatric Aspects of Convulsive Disorders*. Edited by: Paul H. Hoch and Robert P. Knight, Grune and Stratton, New York, 1947, 214 pp., \$4.00.

Epilepsy is coming of age. Our present medical generation becomes an eyewitness to a basic reorientation in the field of convulsive disorders; this has been in preparation for a considerable length of time. The noteworthy progress in medication and the first introduction of a powerful diagnostic tool became the cornerstone of the new approach. The original description of the electroencephalogram opened up new vistas in the field and gave rise to extensive research on an unprecedented scale. Electro-

encephalographic investigations of today seem to have reached far beyond what the originator had thought to be the field of their applicability.

The emphasis on diagnostic-therapeutic evaluation has shifted from the mere neurological point of view to consideration of the total personality. But this our time of psychosomatic awareness, seems still to be very reluctant to incorporate psychiatric and psychodynamic factors into the conception of convulsive disorders.

The book on epilepsy, edited by HOCH and KNIGHT derives its particular value from the strong accent on the psychiatric aspect of epileptic conditions. Psychiatric manifestations can not be considered a coincidental by-product but an integral part of the clinical picture. It is this particular emphasis which seems to justify hopes for a consideration of psychotherapeutic approach in the treatment of epilepsy.

No attempt will be made to give a critical review of every paper, each of which has its merits in tracing the past and present day situation. An historical review and a critical appraisal of the pharmacological approach (BUNKER and MERRIT) form an appropriate introduction. MALZBERG indicates familiar statistical estimates of the intra-mural epileptic population. PRICE, whose name is inseparably connected with the Baird Foundation Clinic as its originator, draws on statistical data of the clinic, which despite their tentative character reveal important implications. He and his collaborators, LEVINE-KOGAN and TOMPKINS, emphasize that the Baird Foundation Clinic was established along the line of child guidance clinics with the exclusive emphasis on epileptic conditions. The pharmacological approach used at the clinic did not yield results which differed considerably from effects obtained in other treatment centers. However, the emphasis on the psychiatric implication and the case adapted psychotherapy remains an inexhaustible source of therapeutic possibilities. It would be tempting to dwell in detail on the remarkable results of the combined treatment approach. In conclusion the author suggests a reclassification of epileptic disorders which should be useful in clarifying the issue.

DIETHELM's description of differential diagnostic possibilities is written with meticulous care and profound understanding. He remains in the realm of descriptive, observational characterization and leaves psychodynamic exploration to MITTELMANN. This author explains psychopathological manifestations in epileptic disorders in terms of reaction pattern to the impact of epilepsy on the individual. The continual reactions are of an aggressive nature or characterized by attempts of withdrawal. The paroxysmal disturbances may lead to submission and masochistic promptings. This paper is very thoughtful, inspiring and deserves thoroughgoing study. This reviewer is inclined to disbelieve the general validity of the formulation. The psychiatric manifestations in epileptic disorders seem to be a non-specific variable, depending on the underlying personality in its psychopathological features.

Needless to say, the problem of deterioration and of the so called epileptic personality dominates the core of the psychological investigations. PIOTROWSKI reports on past and more recent investigations of the Rorschach picture in convulsive disorders. His own experimental approach is very interesting, but does not seem to yield reliable diagnostic criteria.

MAYMAN and RAPAPORT appear to be extremely reluctant to accept the present status in the study of deterioration. Few of the studies do suggest characteristic pattern-like impairment of functioning, shaping up in the course of epileptic deterioration. After a thorough-going review of the literature, Rapaport concludes with an outline of questions and suggestions to be followed in future investigations of convulsive disorders.

HOCH's interpretation of the psychopathological aspects of organic brain damage and experimental work of KOPELOFF and PACELLA, *et al.*, and of PATTON, are all research contributions of considerable value.

The reviewer has little doubt that the book will take a prominent place in the literature of convulsive disorders. Its strong psychiatric orientation is the chief asset of the publication. However, it also shows one important shortcoming. Although psychotherapy of convulsive disorders has proved its value in a considerable number of cases, MITTELMANN gives this aspect only a summarizing account. His paper is devoted primarily to a consideration of psychopathological manifestations, although enough data are available to warrant a separate chapter on psychotherapy of epilepsy.

L. PETER DEUTSCH, M.D.

New York, N. Y.

F. M. DOSTOEVSKY: *Stavrogin's Confession*, Lear, N. Y., 126 pp., \$2.75.

Freud's brilliant paper "Dostoevsky and Parricide" is reprinted in F. M. Dostoevsky's "Stavrogin's Confession." This essay stands midway between his more literary article on Michelangelo's *Moses* and his strictly analytic study of Leonardo da Vinci. It is not easy to see why a paper by Freud intended for Dostoevsky's novel "The Brothers Karamazov" should be reprinted with a fragment from the novel "The Possessed." The dust jacket informs us in large letters that these are "*suppressed chapters*." It is the same kind of sensationalism that added to Freud's paper on Leonardo da Vinci, also separately printed of late, the sub-title, "A Study in Psychosexuality."

The "suppressed" episode described in "Stavrogin's Confession" was really not suppressed, nor is this its first publication. It was published in English years ago, and more than a quarter of a century ago in Russian and German. It has given rise to the malicious literary gossip that the seduction of a child may have been an occurrence in the life of Dostoevsky himself. That is like saying that Edgar Allen Poe and Jules Verne travelled to the moon because they wrote about it.

Although Freud's essay in its own context is very instructive, separate publication of "Stavrogin's Confession" might more usefully, even if less sensationally, have included Maxim Gorky's essays on Dostoevsky, in one of which he says: "It isn't the Stavrogins one has to show at this time, it's something different. What we need is moral health, and action, and not introspection. And what is really necessary for us is to return to the sources of energy: democracy, the people, solidarity, knowledge."

FREDERIC WERTHAM, M.D.

New York, N. Y.

BENJAMIN KARPMAN: *Case Studies In The Psychopathology of Crime, Reference Source for Research in Crime Material, Vol. II.* Medical Science Press, Washington, D. C., 1947.

The present volume of Karpman's monumental work on the psychopathology of crime contains a presentation of four cases (in addition to the five cases contained in Vol. I). The crimes are: theft of the United States mail, violation of the Mann Act, rape and train robbery. The cases are described with exemplary scientific care. The complex structure of the emotional personalities of the patients is presented with precision and lucidity, which makes reading of the sordid material interesting and instructive.

Throughout the book Karpman's own compassion for his "doubly unfortunate friends, the criminal insane" is keenly felt. It is this compassion that has undoubtedly paved the way for the patients' cooperation in making possible the production of this material. Each case contains the official records of penal and mental institutions, the patients' life histories and crime histories, as well as the psychological findings based on all pertinent factors. The book also casts light on the disciplinary methods employed in some of our penal institutions, which will no doubt evoke critical comment. On page 656, we read the following description which might have been written in the Middle Ages: "He (the criminal) was handcuffed to his cell door for seventy-eight days and during this time for twenty-one days he was given only bread and water. The solitary confinement precluded any possibility of reading or recreation, and this preyed on his mind so much that he felt he was going crazy. During these months of solitary confinement the patient claimed he had swings of mood, alternating depression and feeling of well being; whether or not this ever went beyond the normal limits is uncertain. On several occasions he lost his temper and called the warden various vile names. Unable to stand it any longer, he began, at the end of fifteen months, to hunger strike, stating that under such conditions death was preferable to life. It was under these circumstances that he was finally transferred to St. Elizabeth's Hospital. He immediately began to eat when the official notice of his transfer was received."

Considering the natural limitations of collecting material, Karpman's results are very impressive. His work does not intend to show psychotherapeutic achievements, although the catharsis itself must have been beneficial to many of Karpman's patients. What Karpman wants to demonstrate is his thesis that delinquency is a social neurosis and that a thorough study of cause and effect may help society to conquer this evil by more effective means than the effort of the individual psychotherapist.

EMIL A. GUTHEIL, M.D.

New York, N. Y.

CHARLES BERG, M.D.: *Deep Analysis. The Clinical Study of an Individual Case*, W. W. Norton and Co., N. Y., 1947, 254 pp., \$3.50.

This is probably one of the most important psychoanalytic books published in recent times. It describes the full course of a psychoanalysis. You hear and see the patient speak and act and you see and hear the doctor. The case example is a fortunate one because the patient did not fall into any well-established clinical entity, "by virtue of his freedom from overt symptoms." That, incidentally, does not give the author the right implied in the text and clearly stated in the advertising to say that "almost all psychopathic aberrations including frigidity, impotence, hate, hysteria, obsessions, and even paranoia and schizophrenia (are) all present in minor degrees in normal personality."

When I read the galley proofs of "The Frozen Sea," a very good book on Franz Kafka by the literary critic Charles Neider, and was asked whether it was scientifically correct, I said that it was entirely in accordance with what happens today to thousands of patients treated by orthodox psychoanalysts. According to Neider, Kafka's novel "The Trial" represents the dynamics of the castration complex, and his novel "The Castle," the Oedipus complex. Berg's "Deep Analysis" bears this out in great detail, for the more the psychoanalysis progresses, the more the range of psychodynamic emphasis is narrowed down to the Oedipus complex and the castration complex. Why, you may ask, could that not be true in this actual case? Unquestionably it could. But if one reads this book carefully one realizes, thanks to the lucidity and sincerity of the author's presentation, that there are indications of other material which is forced into this form.

To my mind this book clearly indicates the precise point where orthodox psychoanalysis as Freud left it falls into the danger—a danger that faces any science in the hands of epigones—of becoming fossilized and as unadapted to reality as the patients whom it wishes to adapt.

Two major criticisms, therefore, have to be made of this book. One is based on the principle that it is up to the analyst to decide when sufficiently dynamic material has been uncovered (Gutheil). The second criticism is that the book is restricted to the elucidation of what I call micro-

dynamic factors, leaving out any recognition or evaluation of the social and historical medium in which this patient develops and without which neither he nor his neurosis nor his psychoanalysis nor his analyst can be scientifically understood (what I call *macrodynamic factors*).

This is the type of book which has the faults of its virtues. It can be very highly recommended to three classes of readers: the beginner in psychoanalysis, the practicing psychoanalyst and the few scientists in psychotherapy who are at present engaged in the arduous task of safeguarding the heritage of Freud by developing it further.

FREDERIC WERTHAM, M.D.

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BERTRAND S. FROHMAN: *Brief Psychotherapy, A Handbook for Physicians on the Clinical Aspects of Neuroses*. With a foreword by Walter C. Alvarez. Lea & Febiger, Philadelphia, 1948, 265 pp., \$4.00.

Frohman's book is an important contribution. Its chief merit is that it is practical, and that it appeals to those who are in want of an authoritative guide in practical psychotherapy. Although it emphasizes the short-term method, it also gives a good overall picture of the present trends in psychiatry and psychotherapy. The general practitioner as well as the specialist will find *Brief Psychotherapy* useful as a reference book.

The material is well organized and presented in a fluent style. The description of the most important clinical entities is supported by short and instructive case histories. The book can also be perused with profit by prospective patients who wish to obtain authentic information on mental conflicts; a glossary which has been added to the book will be of great help to them. All in all, an excellent and useful book that stands out among the current publications on this subject.

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ABSTRACTS

(A) PSYCHOANALYSIS

Displacement Guilt and Pain. Henry Hart, *The Psychoanalytic Review*, Vol. 34, No. 3, July 1947.

Starting with the statement that "The basic concept of displacement is a mechanical or physical one inherent in the libido theory which represents libido as a more or less constant quantity of psychic or instinctual energy available for the organism," the author demonstrates the nature, direction and the organic corollary in cerebral function of displacement guilt and pain.

It is stated that "displacement of instinctual energy is a normal phenomenon in healthy adapting man, but abnormal in . . . animals . . . where the instinctual energy cannot be much changed or adapted to changing circumstances" and that, "we are dealing in psychoanalysis with displacement that is abnormal in the sense that instinct is not sufficiently satisfied by the new channel of expression and decline in reality mastery results." The directions of pathological displacement are enumerated as (in summary): regression from a later to an earlier pleasure, projection from an internal to an external object, introjection from external to internal object, symbolization, and shifts between body parts and whole or from an affect to an idea. "Rarely, except under the stern pressure of necessity do we turn from the trivial to the ideal and significant; "rather turn away from painful reality whether external or internal in order to defend the ego." Examples such as falling in love at first sight, totemism, obsessive heterosexuality, compulsive overeating and stealing, generalized irritability, race prejudice and national aggression, hatred of places, etc. "The more complex type of displacement so characteristic of compulsive neurosis is the displacement from vital to insignificant," e.g., doubt about vital issues such as the choice of a sexual object to the details of living (Freud), the displacement of guilt away from sexual reminiscences, from the important weak points, etc., from polygamous tendencies to collections of harmless objects (Stekel), masochistic displacement to symbol substitution and detail (Reik).

Many examples are given of hysterical displacement between various parts of the body, especially genital, oral, gastrointestinal zones. It is noted that the mechanism of displacement is repressed, unconscious, operating in response to culture pressure and centrifugally away from the more painful emotional states of shame, guilt, and anxiety, to a less emotionally disturbed state such as conversion symptoms, obsessive rituals, compulsions,

tics, etc. "Anna Freud says that the readiness with which instinctual processes can be displaced assists the mechanism of sublimation." Both sublimation and aggression are displaced toward less dangerous objects, and further, some displacements are more satisfying and stable because many component drives are acceptably satisfied. Guilt, as in syphilophobia or stealing to seek atonement for more painful repressed drives or acts is mentioned.

It is stated that "Phylogenetically, guilt would appear to be a relatively recent acquisition" and that "It is interesting to note that man, who of all animals seems to be the most capable of enduring pain, is at the same time least able to endure guilt"; further, "Thousands of examples could be marshalled to show that physical pain is more endurable than the mental distress of anxiety." It is then pointed out that "what is peripheral to the body as well as to the psychic ego is more accurately perceived," that in many somatic conditions pain is referred, poorly felt or absent, especially in visceral disorders and in injury from within, like malignant neoplasms. However, the localization of displaced psychic pain appears to conform with the talionic law, although the actual mechanism is poorly understood, but "no active transmission of nerve impulses is actively involved. The projection of the pain and the hysterical conversion mechanism is more like the pain referred to an amputated foot, in other words central and cortical."

Neurophysiological opinion of the ego function of the cortex, which has no direct control over the emotions, and the damping effect of the cortex on painful stimuli is quoted. Note is made of emotional lability found when the cortex is not functioning, and that since this is the case, "It does not seem too wild a guess that the displacement mechanism is likewise seated in the cortex with its repressive or inhibitive tendencies." Using the reasoning and evidence above, the author summarizes as follows:

"1. The guilt and anxiety are affective states so painful and disagreeable to man that he is obliged to protect himself against them by various devices. 2. The chief defensive device is that of repression and displacement, working in coordination with one another. There is, therefore, no repression without some displacement and no displacement without some repression. 3. That the tendency for displacement is centrifugal from the central part of the ego to the periphery in the somatic or body ego. 4. There is an afferent hierarchy of pain, some pain being more endurable than others, and somatic peripheral pain projected in either hysterical conversion symptoms, or in psychosomatic disorders, is more bearable than the affect of guilt and anxiety. 5. The tendency to displacement of pain is according to symbolie pattern whereby the organ or part symbolizing the guilt agent becomes the part "punished" by pain. 6. The pattern or easy displaceability of instinctive or id drive forms the basic pattern for displacement of pain and functional disturbances to symbolically equivalent

zones of the body. 7. Search for analogous mechanisms in the neurophysiology of pain indicates some similarity in referring pain from the viscera to the periphery according to segmental pattern. 8. Reception, interpretation, projection of and response to pain stimuli are functions carried out chiefly by the cerebral cortex. 9. Accordingly, it seems logical to assume that the capacity of the ego unconsciously to displace guilt affect into peripheral somatic pain is a part of the function of the cerebral cortex, or the cortico-thalamic organization."

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(B) PSYCHOTHERAPY

Fundamentals of Psychotherapy and a New Orientation, Marshall C. Greco and Irving B. Fecher, Orthopsychiatry, Vol. 17, No. 3, July 1947.

The authors, who are psychologists at Western State Penitentiary at Pittsburgh, Pa., produce here both a criticism of present psychotherapeutic methods and a new counseling orientation.

The methods of freudian therapists and followers of Horney and Rogers all make use of similar learning situations, they say, which are diversely manipulated to cure the patient and are all based on the assumption that the cause of the neurosis is the subject's own deficiencies.

Although Horney has advanced beyond the freudian concept of infantile instinctual strivings and endeavors to show that the power of the neurosis is derived from culturally determined "basic anxiety," she has fallen into the same error of being preoccupied with the patient's weaknesses. The mechanics of her psychoanalytical procedures resemble Freud's also—the treatment situation is a learning situation, and the therapist is able to impart this education by means of transference. Rogers also utilizes the patient's deep feelings for the therapist (transference) which are developed as a result of his acceptance of the patient as a person. The acceptance and objectivity concerning himself which the patient feels stimulates him to growth; this self-education is one feature of the Rogers therapy which differs markedly from the freudian therapy, but there is, in the authors' opinion, a difference of degree only.

Insight cannot be achieved by the freudian method of making the neurotic believe his difficulties are derived from hereditary, instinctual, and infantile experiences, or by the Horney method of dwelling on his neurotic trends, or by tacitly condoning the patient's feelings of personal deficiency as the Rogers method seems to do. Treatment must not permit the subject to be blamed for his conflicts and failures. The blame belongs in the total sociopsychological milieu which fostered his contradictory strivings and frustrations. This requires a directive approach with strong counselor influences to see life as it is. The client would be motivated to change, not

because his characteristics are intrinsically bad but because they are ineffective in his environment.

A trait that is encouraged in one situation may be condemned as maladjustment in another; yet the patient is blamed for his frustration when this occurs. If it were not for this self-reference factor, the authors aver that neurosis might never exist. They believe that the counselor's first duty is to counteract the tendency toward self-reference by orienting him with an appreciation of his "contradictory strivings in relation to the incompatible demands of his social settings." Instead of speaking of a client's tendency to project his deficiencies onto his environment, the authors speak of self-reference introjection of environmental deficiencies.

Since the authors' therapeutic practice is limited to inmates of a penitentiary, they do not feel able to generalize on the use of situation-oriented therapy with other problems. They also do not feel that they have developed all the interviewing techniques possible with an inmate population. They do emphasize circumstances and relationships (rather than personalities) as the causative factors in maladjustment. They present an interview with an inmate who has strong, generalized negative feelings about society which he blames for his shortcomings and failures. By their method he will realize he must not blame, will sense less hostility in others, and will be predisposed to development of normal emotional relationships.

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(C) PSYCHOSOMATIC MEDICINE

Brief Psychotherapy in Psychosomatic Problems, Roy R. Grinker, Psychosomatic Medicine, Vol. IX, March-April 1947, page 98.

The distinction made between psychoneurosis and war neurosis in Army disabilities on the basis of the duration or severity of stress that preceded the illness is unwarranted because the psychology, the symptoms, the dynamics, the severity of the illness and its recoverability show no corresponding difference. Although it can be stated that the combination of a meaningful stress and a susceptible personality are requisite for the development of the illness, it cannot be predicted which individuals will suffer in this way. While vomiting and diarrhea were almost a universal reaction to fear, hopelessness or rage, most men were able to continue functioning. Some men were disabled by the severity of these reactions or by their persistence after the subsidence of provoking strains, or by recrudescence on slight difficulties.

The emotional needs liberated by these situations are discharged through visceral innervation. The attempts to explain these reactions have been based on the psychoanalytic principle of correlating specific emotional needs with specific symptoms and the psychosomatic attitude that specific

personality profiles accompany certain visceral disturbances. These assumptions are summarized in four propositions:

I. A specific repressed unconscious need is related to development of a specific visceral syndrome—as peptic ulcer. II. The total personality expressed by its external and conscious attitudes is specific for a visceral syndrome since it consists of characteristic reaction formations and compensations which are complex derivatives of the opposing psychological forces which prevent a specific need or feeling from becoming conscious. III. The visceral dysfunction does not represent central conflict but is an exaggeration of the normal visceral concomitant of the unexpressed specific emotion. IV. Long-standing visceral dysfunction eventuates in permanent morphological change.

In his analysis of these formulations on the basis of war experience, the author has not found them helpful or valid with the exception of the third instance.

The theoretical formulations of psychosomatic medicine have no corresponding wide-spread practical application. Psychiatric care is not available to many who need it. In the present situation, short-cuts in therapy are essential to meet the situation. A case in which this was applied is quoted.

This case exemplifies the “principles of brief psychotherapy of acute psychosomatic states.” It is based on the uncovering of etiologic repressed emotion and connecting it with earlier emotional patterns—ultimately reorienting the defective attitudes and responses.

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New York, N. Y.

Learning as a Psychosomatic Problem (Round Table Conference 1946), Edward Liss, M.D., Chairman, American Journal of Orthopsychiatry, Vol. 17, No. 3, July 1947.

Educators agree that children are not utilizing their natural resources to the fullest extent possible. What are some of the causes for this failure? The members of the round table discussion contribute their ideas, observations and opinions in the hope that a psychosomatic approach will help develop an understanding of the processes of learning and the reasons for failure to learn.

S. Howard Bartley of the Dartmouth Eye Institute presents four examples of ocular learning to support his statement that learning involves psyche and soma in an integrated unity. An experiment was performed to show the pupillary light reflex when each eye was stimulated independently of the other and observed by infra-red photography. The pupils of both eyes constrict following stimulation of the first eye but begin dilating when additional stimulus is applied to the second eye; after maximum dilation

increased stimulus causes the pupils to constrict again. Another experiment, in extension of Fechner's paradox, reinforces the obvious conclusion that reflex and sensation are parallel and that when meaning is ascribed to the sensation, the reflex behaves accordingly.

The "psychosensory restitution phenomenon" in pupillary behavior as reported by Lowenstein is adduced as another example of learning. Bartley says that the pupillary response is determined by the significance of the stimulus to the organism and that the diminution phenomenon is one of learning rather than fatigue.

There are some behavioral complaints, such as periodic blurring and the inability to make appropriate motor adjustments, which are conditioned responses to emotional conflicts. An example of this is blurring of vision when one is losing at cards or otherwise feeling inadequate or disturbed in situations requiring nice use of the eyes. Another example of pupillary learning is found in the ability of some well-adjusted persons to tolerate peripheral optical deficiencies while others develop intolerance to them. Optical treatment of the latter group would be absurd.

Learning problems in the language field are most puzzling when there is a scarcity of somatic deficiencies to account for them. Edwin M. Cole of Massachusetts General Hospital has found no pathology in language handicaps like poor eyes or ears, low I.Q., poor body co-ordination or environmental or emotional troubles. This observation is also made by Ellen K. Donohue of Ethical Culture Schools, New York. She does assert that learning problems must be identified early in a child's life in order to prevent a grave and elaborate handicap in adult life.

Sometimes a carry-over of techniques is a cause of failure in learning; the child tends to look all over, then up, down, back and forth. This is obviously a handicap in learning to read, says Arthur I. Gates, Teachers College, Columbia University. He has also found that a child accidentally develops inappropriate learning techniques. These, poor teaching, lack of adequate motivation to learn and constitutional factors comprise most of the causes of learning failure. Remedial treatment, he believes, may be applied with almost any method whether phonetic or kinesthetic.

Returning to consideration of learning problems with a somatic basis, Cole states that many somatic handicaps are not readily recognizable. When they are not recognized, individuals are expected to perform in a way they are not constitutionally able to do, and this frequently causes psychic trauma or the development of compensatory symptoms which further handicap the individual.

Conrad Berens and Marjorie Enos of Columbia University have found that though the majority of patients do not have reading difficulties primarily because of ocular disability, there are some cases of ocular disability which emphasize the necessity for careful ophthalmological examination

in every case. Motor anomalies, most common of which is convergence insufficiency, are among the most frequently observed conditions associated with reading disability. Berens presents six cases, five of which concern motor anomalies and one macular degeneration with an apparently hereditary basis. Usually the patients had other complicating conditions, such as sinusitis, hypothyroidism, allergy. Hyperphoria and aniseikonia were sometimes associated with other motor anomalies. He concludes that it is impossible to investigate any organ system without considering other factors related to the whole organism.

The present isolation of specialists from each other prevents any successful development of an individual's potentialities. The chairman suggests that a group approach to the problems of learning must be made. Although language and reading difficulties have been exclusively discussed in this paper, Liss points out that arithmetic and the arts, all essential to the practical and healthful functioning of the individual, also present learning difficulties for some persons and that the same observations of sensory conditioning and learning techniques apply in those fields as well.

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New York, N. Y.

Somatization Reactions, William C. Menninger, Psychosomatic Medicine, Vol. IX, March-April 1947, page 92.

The term "psychosomatic" has developed two meanings: (1) The point of view which considers the individual as a whole and does not neglect the personality reactions in diseases of all sorts, even those most obviously attributable to physical causes. (2) A classification applied to a limited number of diseases whose nature cannot be understood without adequate consideration of the emotional life, such as hyperthyroidism, gastric ulcer, etc.

In spite of many observations of the importance of both these attitudes, medical education neglected these approaches until recently. The second world war with the tremendous effect of psychological strains on millions of normal individuals brought this approach to the fore. Figures are quoted indicating that 20-40% of patients in hospitals for gastro-intestinal and cardio-vascular complaints suffered from psychogenic disturbances and not from structural diseases. The chief physical conversions were expressed by the gastro-intestinal, cardio-vascular, skeletal (rheumatic) system, and by allergic manifestations.

Efforts to meet the problem in the army were divided in three parts: (1) Orientation of the physician to the problem; this included the recognition of psychological factors, methods of explaining these to the patients, and realization of the interest inherent in these cases. (2) Cultivation of an understanding of dynamics of personality. This includes emphasis on

the unconscious, and the influence of unconscious tension on physical function. Stress is placed on understanding of anxiety and the various modes in which it may be expressed and handled—as in psychological symptoms, behavioral disturbances, conversion phenomena and organ neurosis. (3) Comprehension of individual choice of symptoms, that is, the personality-structure of various organ-neuroses.

Due to the frequency of somatic complaints in neuroses a change in nomenclature of this group was introduced. In addition to the subgroups already formed as anxiety reaction, dissociative reaction, phobic reaction, conversion reaction and other neurotic responses, a special subgroup for these somatic responses was introduced under the title "Somatization Reaction." Under this heading will be mentioned the system or organ involved as psychogenic gastro-intestinal reaction, psychogenic cardiovascular reaction, psychogenic genito-urinary reaction, psychogenic allergic reaction, psychogenic skin reaction. An additional subheading is the psychogenic asthenic reaction—where fatigue is the outstanding complaint. Each subheading is to be further clarified by mentioning the outstanding symptom involved as anorexia, palpitation, dysuria, etc.

New York, N. Y.

SIDNEY ELPERN, M.D.

Biologic versus Chronologic Age, Harry Benjamin, Journal of Gerontology, Vol. II, No. 3, July 1947.

How old is old? As the percentage of aged persons in our population increases, the possibility of increasing the span of active life becomes more important. Understanding what constitutes "biologic age" will help medical men provide an optimum life for their patients.

Biologic age is determined by heredity, state of health and functioning capacity. It may be higher one year and lower the next, or the reverse. Various medical tests have been devised for measuring it. But valuable though they are, Benjamin believes they express the age of one organ or the quality of one function rather than the age of the whole individual. He proposes a systematic method for estimating the biologic age with the realization that it will require improvement in the future. There are also three principal difficulties with the attempt to measure biologic age: (1) various organs and organ groups do not age simultaneously; (2) the designation of normalcy is arbitrary and dependent upon experienced, critical observation; (3) a diagnostic method is only as good as the quality of its interpretation.

Persons selected for estimation of biologic age should be over forty years by the calendar and should be in average good health (a patient chronically or seriously ill would be as old as his sickest organ). Benjamin suggests a health inventory consisting of twenty factors to be rated selec-

tively and individually. Only those health factors which differ from the average should be rated. Heredity and constitution, personal history, living habits, metabolism, nervous system, mental functions, endocrine system, sexual functions, genito-urinary functions, blood-lymphatic tissue—tissue fluid, digestive system and respiratory system are judged by adding or subtracting from 5 to 20 years from the chronologic age. The ~~cardio-~~vascular system is rated by from 5 to 30 years, the skeletal-muscular system 5 to 15 years, eyes and ears each 5 to 10, while skin, hair and nails, teeth and jaws rate 5 each. Additional assets or handicaps may rate from 5 to 20 years. Adding the individual scores and dividing by the number of factors considered, the average obtained represents the patient's biologic age. A further suggestion is the preparation of score cards for each factor judged. These cards contain subdivisions to be rated as favorable or unfavorable; the total impression then suggests how to modify the chronologic age. Certain other modifications may need to be made. For example, a man with chronic arthritis but with a long statistical life expectancy would still be rated as biologically rather old. Some persons who fall below the level of average good health may be benefited by separate calculations of assets and liabilities and encouraged to have treatments to increase their health and with it their biologic age.

Some advantages of biologic age estimation are the following: routine annual health check-ups would be encouraged; employers and employees would benefit from a listing of biologic age with chronologic age, both at time of application for employment and at time of pensioning or release from work—those capable of working would continue to work while those too aged to perform their present tasks would be removed to appropriate positions or retired; persons with biologic age lower than the chronologic age could be induced to preserve their advantages; no person could be elected to responsible public office whose biologic age was over 60 or 65.

Considering the present emphasis on prolonging life, Benjamin believes more effort should be made to provide man with a living rather than a dying old age. He has offered his system of measurement hoping it will encourage others to modify and improve it, thereby increasing general interest and ultimately the prospects of an enriched life for the aged.

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(D) CRIMINAL PSYCHOPATHOLOGY

Passive Parasitic Psychopathy, Ben Karpman, The Psychoanalytic Review, Vol. 34, Nos. 1 & 2, January and April 1947.

It is the author's theses that of the large group of patients designated as "psychopaths," the majority can be said to have psychological motivations for their actions, so that "instead of being true psychopathies, they

the unconscious, and the influence of unconscious tension on physical function. Stress is placed on understanding of anxiety and the various modes in which it may be expressed and handled—as in psychological symptoms, behavioral disturbances, conversion phenomena and organ neurosis. (3) Comprehension of individual choice of symptoms, that is, the personality-structure of various organ-neuroses.

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are merely psychopathic-like reactions that belong nosologically to the various cardinal psychiatric groupings: neuroses, psychoses, epilepsies, etc." Accordingly, this division may be designated as symptomatic or secondary psychopathy, which may yield to treatment when the underlying cause is treated. This group comprises by far the greatest number of people commonly included into the group of psychopathy.

"In the remaining group, even when considerable effort has been made to unravel the conditioning psychic factors, such do not appear to be present. The reactions appear to be so deep-seated and ingrained as seemingly to be unreachable by the usual psychotherapeutic approaches, and are as close to what is commonly called constitutional as a case could be. This group is designated here as primary idiopathic, or essential psychopathy (anethopathy)." Of these, two subgroups are said to be observed: "the aggressive-predatory type" and "the passive parasitic type."

It is with a detailed case presentation of a patient of the latter subgroup that the two installments of the present paper are concerned. The patient's history itself can be summarized by stating that he demonstrates a long series of struggles with the law, inability to profit by experience or conform to group behavior. There was no evidence that this man ever suffered any remorse or guilt feelings whatsoever, nor did he show any gratitude or appreciation. He had always taken whatever he wanted, without thought of the future, past or of anyone but himself . . . "it was impossible to inculcate in him conceptions of right and wrong." His fantasy and dream life was simple and primitive, concerned mainly with wants and needs, lacking the complex symbolic fabric found in neuroses and psychoses. "His sex life parallels his life in general and suggests the same lack of organization and control, and obedience only to the law of self-gratification. It was mainly on a heterosexual plane, but almost any female would do, and paraphilias readily resorted to in case of privation or in prison. Here, as elsewhere, he would follow the instinct to the point of exhaustion." Emotional life was similarly superficial and simple. Intelligence was normal, but affected by the patient's poor judgment.

In discussing the patient's character structure, the author points out that there was no evidence of any conditioned emotion, affection or gratitude of any kind. There was, further, total absence of any oedipal reaction, guilt, remorse and even of any unconscious mechanisms at all (?), nor is there any insight by the patient into any phase of his character. "In his sex life, he has the same parasitic attitude as in other life relations. The sexual partner never means to him more than only a means to an end, someone to minister to his needs. The more a woman can satisfy his needs, the more he likes her; that over, he has no further use for her. Like in everything else, he indulges in sex to excess, and to the point of exhaustion; there is complete lack of restraint." His essential behavioristic traits are infantilism, weakness and social isolation.

Commenting on the patient, the author remarks that he is a "socially worthless individual" who has remained throughout life exactly as he appears to have been at birth—primitive, animalistic, unteachable, unconditionable, to whom the world about him existed only for the purpose of feeding his ego and who could never be persuaded to view it any differently." Finally, it is noted that "against all expectation, the therapeutic efforts seemed not to have been entirely fruitless, as the man appears to have been able to maintain himself after leaving the hospital without getting into trouble for eight years, by many times the longest period in his life. This provides the hope that such individuals may profit by treatment, even if to a limited degree, especially if they are put in a protected and sheltered environment, that recognizes their basic traits."

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Notes on "The Iceman Cometh," William V. Silverberg, *Psychiatry*, Vol. 10, No. 1, February 1947.

The clue to O'Neill's play about the disillusionment of a group of alcoholic derelicts is in the title, a parody on the New Testament phrase: "Behold, the bridegroom cometh." The bridegroom represents the savior who shall redeem the world with love, but the iceman is the modern would-be savior who comes with coldness, hatred and scorn. The analogous antithesis is that of science and religion. Freud called religion an illusion and found support in science. O'Neill agrees with Freud and Marx about religion, but says that mankind is not yet ready for disillusionment; whoever attempts to emancipate man with haste, impatience or violence is motivated not by love but by hatred, scorn and bitterness. The play seems to deplore the fad for debunking and in this sense associates Freud with the iceman, but Silverberg denies that psychoanalysis has been the villain in the precipitate disillusionment of man and asks what other endeavor is better suited than psychoanalysis to aid man to surmount the obstacles and barriers to genuine love.

BARBARA KELLY

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(E) ANTHROPOLOGY AND PSYCHIATRY

The Cornerstone Ceremony, Jacques Schnier, *The Psychoanalytic Review*, Vol. 34, No. 3, July 1947.

The author uses anthropological, sociological and psychiatric data to arrive at the meaning of the ceremonies performed in connection with starting the foundations of new buildings.

Commencing with examples of the sanctification and rituals associated by many peoples both with the beginnings of any tasks and with buildings

themselves, the author mentions many sexual and animal taboos observed by primitives, such as periods of penance, continence, rituals to drive away evil spirits. In addition, reference is made to Frazer and other sources who record the incorporation within the building stones of live animals, human and animal blood, or symbolically, a man's shadow, carvings of his name, images, games, tools etc. The report is included of an eyewitness account about 100 years old of the Fiji custom of burying men alive in the post holes of a new house. The sacrificial eating of children, the finding of adult, or more often children's bones in the foundation stones are further listed, together with the murder of slaves, pregnant women and children often accompanied by the elaborate ceremonies found in Assyria, Egypt, Greece, Babylon, Alaska, Central Europe and elsewhere; "As late as 1843, in Germany, when a new bridge was built at Halle, a notion was abroad among the people that a child was wanted to be built into the foundation." The records of the Christian Church state that the bones or relics of martyrs were used in dedication. The deduction is made that the Holy Eucharist is the symbolic and sacrificial eating of the flesh and blood of Christ and then, that since the Eucharist may be substituted for the relics of the martyrs, the relics represent a sacrifice; thus leading to the conclusion that "the victim of the sacrifice is either eaten or buried in the foundation."

Next, the conclusions of Freud in *Totem and Taboo* and of Money-Kyrle in *The Meaning of Sacrifice* are accepted, namely: that the "sacrificial victim symbolizes the father" and, therefore, that "even the props and equipment used in foundation ceremonies of secular buildings, of schools, city halls, office buildings and city walls, all represent a sacrificial victim, the dead father." Further, the author quotes some Jewish and Christian religious sources and some ancient rituals to show that "Symbolically, the house is the mother, or the mother's womb, and the correctness of this interpretation is amply affirmed by anthropological, historical and psycho-analytic literature." The symbolic meaning of the city and the bridge are brought out, the former female and the latter male.

Finally, using the evidence that has in part been mentioned above, "like a detective, we have carefully gathered clues for solving our murder ritual. . . . The apparently innocuous articles, such as portions of the Gospels, the letters of an organization, an old martyr's relics, or a slaughtered lamb, have been traced to the body. The body has been identified as that of the father. He has been murdered in close proximity to the mother or where she has been expected to appear. More often he is destroyed at the portals of her womb.

"We are now ready to deliver the indictment. When man undertakes the construction of a new building, he phantasies the completed building as the mother. By means of the portals, gates or doors, she will become

available to him for symbolic intercourse or a symbolic return to her protection. In the case of the bridge, the newly constructed phallus reaches out to her. In his unconscious, he anticipates an orgy of sexual activity or a return to that from which he was separated. But the thought of recovering the mother arouses terrific fear of the father. It causes an anxiety of such potential that it can only be released by eliminating the father. This he does by destroying and burying him at the very entrance of the womb. Henceforth, each time a superstitious man enters or leaves a house, a church, or a city, he is unconsciously reminded that buried beneath the threshold lies the dreaded father and henceforth he need never be feared again. But for those who cannot cross the threshold of a building or of love, the feelings of guilt and the dread of retribution for having castrated the father outweigh the feeling of security and satisfaction that should have resulted from the deed."

DONALD B. DOUGLAS, M.D.

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The Concept of Culture and the Psychosomatic Approach, Margaret Mead, Psychiatry, Vol. 10, No. 1, February 1947.

Current discussions in psychosomatic medicine have not yet incorporated the implications that every human being has had some of his potentialities selected by culture for elaboration, other potentialities ignored and others suppressed. There is not one biological characteristic or form of behavior that has not been thus fashioned according to the demands of culture.

In one sense, every psychiatrist, psychoanalyst or wise physician does consider the effect of culture in his observations of individuals—but he calls it "human nature." The author, who is an ethnologist, points out that the terms "normal healthy," "text-book normal" and "social history—essentially negative" are all recognitions of the basic influence of culture. The individual who has made the same compromises with his body and the same somatic symbolizations as the majority of his fellows would be normal and healthy. A text-book normal chest may be found in Samoa. And a completely negative social history would simply document the successful molding of the individual's personality to the cultural norm.

Sometimes the term normal is used to designate the statistically normal, without recognition that this is culturally relative. By means of regional comparative data, as in the study of pellagra, or through some new discovery in bacterial control, as in "summer complaint" of infants, elimination of so-called statistically normal conditions is obtained.

A biological, or basically human normal (meaning by "normal" what form human behavior would "naturally" take if it were not distorted by environmental pressures) really always includes that particular variant of human culture which given individuals use as their basic instrument of

survival. It is not enough, then, to say that a personality is limited and defined by constitutional type, is subject to accidents of social development and is acted upon by environmental pressures; and further, that the personality may develop psychosomatic defects which may be either reversible or irreversible. Culture does not consist of a set of external impacts and catastrophes to which an undifferentiated organism is subjected, but is actually a principal element in the development of the individual causing him to have a structure, type of functioning and a pattern of irritability different from those of an individual socialized within another culture. It is in this conception that a large number of tendencies observed by students of psychosomatic medicine become irreversible. A Samoan, for example, is accustomed to sit cross-legged on the floor. He can with practice learn to sit in a chair without feeling special fatigue, but because of all his customs and behavior patterns related to sitting, he cannot be expected to sit in the chair as an integrated human being—he would be upsetting his whole orientation in human relations.

In a homogenous culture it is readily observed that the molding of the young organism is a function of the entire cultural scheme and is systematically related to all other molding. A parent's preoccupation with a child's intake of food, for example, may result in the child's preoccupation with evacuation; this will in turn help to shape the parent's attitude towards the child's evacuation habits; and still another factor in the training of sphincter control will be the culturally standard behavior for adults in a stage of life not yet reached by the parent.

But in a heterogeneous culture, such as our own, no such systematic interrelationship may be seen. Each individual's cultural experience differs greatly from the experience of other individuals with whom he associates. If he feels inadequate in some way, he attempts to negate this difference by saying, "I never had a chance," or by using the past as a foil for any positive achievement in the present, or by assuming the protective coloration of similar clothes and mannerisms to blur his parentage and background. Because of this emphasis on the past it is common to consider each patient as a special distortion of what would otherwise have been a "normal" personality, instead of merely as a slightly variant representative of a cultural type. A Freudian psychosomatic case-record, in which no deviations from a "normal" development were found, would contain the verdict "social history—negative." Analogously a physician of fifty years ago whose patient ate a conventional diet for that time or a physician of today who has supervised his patient's diet since birth might consider the dietary history negative. It would be as absurd to omit culture from a psychosomatic study as it would be to omit culture from a study of diet.

Studies of asthma, anorexia nervosa, hypertension, Graves disease, *et al.* show the effects of culture on the organism. Every individual, not just

every patient, may be viewed psychosomatically; individuals with definite organ neuroses are merely extreme and special developments of one potentiality of the total personality. There is in fact no basic "human" personality. Everyone is an idiosyncratic variant of cultural development. If students of psychosomatic medicine included in their view-point that the extent to which a patient is "normal" and his life history "negative" to that extent he is a specimen of a special type of molding peculiar to his culture, each special disease picture would assume a different significance. The standard compromises of the healthy American could be documented and would reveal him as a product of progressive and regular patterning which would probably make him subject to certain ways of dying.

The cultural effect upon the total function of the individual is readily seen in postulating two cases of Reynaud's disease, each under different climatic conditions, or two cases of angina pectoris, one in China and one in the United States. There is a definite pattern of interaction between the psychosomatic functioning organism and the cultural system. In Graves' disease for instance, anxiety may be an idiosyncratic feature of the individual life history or a function of a general social situation, such as wars and depressions. Supposing a type of culture which systematically exerts anxiety-producing pressures at critical stages in maturation, a chronic alteration in thyroid metabolism may be expected to which other homeostatic systems would adjust themselves. It is thus seen that culture affects the most fundamental life processes, causing them to have systematically different patterns.

Is there a definite correlation between concentration of deviant attitudes in specific somatic symptoms and the lack of homeogeneity of the culture? The author believes that there is. In a heterogeneous culture individual life experiences differ so markedly from one another that nearly everybody may find the existing cultural forms of expression inadequate for his use and so be driven into specialized psychosomatic forms of expression. During periods of emigration, labor migration, rapid growth of cities with mixed origin, during war and revolution, the culturally disoriented person is subject to new strains of loneliness and isolation without having the usual cultural means of reducing the resultant tensions. One's own body and its immediate environment become the battlegrounds of psychic conflict. Other members of the family or environmental group often contagiously display the same symptoms. This perpetuation of psychosomatic disorders could be averted by reintegrating the individual into the cultural group.

In fact, disorders which are now considered irreversible can be prevented. A broad health plan needs to be devised which would include psychosomatic and cultural aspects of etiology. Some emphases in socialization may need to be changed or compensatory cultural forms adopted to ease somatic and psychic strain. But in any case, a psychosomatic method

which does not use culture as a background is not much farther advanced than the old concept of the dualism of mind and body.

BARBARA KELLY

New York, N. Y.

Witches and Psychiatrists, Donovan Senter, Psychiatry, Vol. 10, No. 1, Feb. 1947.

Witchcraft still flourishes in the Spanish American villages and Indian Pueblos of New Mexico. Despite the increasing influence of public health services, the slow, steady Anglicization of rural areas and the more frequent willingness of native "doctors" to modernize their methods, psychiatric problems are still treated by witchcraft.

The native theory of disease is based on the concept that foreign material enters the body of the victim. Mental illness, family, economic and social problems may be caused by eating or drinking something over which a witch has cast a spell or into which a hair has been dropped. For complete control over a victim, the witch makes an image of clay or other material which contains some of the victim's bodily excrement or which has been previously touched by his shadow, then sticks pins into the image or buries it under hearth stones.

The diseases commonest and easiest to treat (namely, eat a bowl of very hot chile con carne with garlic to avoid catching cold; drink a cupful of fresh hot deer blood for heart trouble) are often handled by relatives without recourse to a "doctor." Whenever psychological as well as physical maladjustment is recognized, however, the specialist is consulted.

Suppose a witch has asked a victim for a glass of water and, while the victim's back is turned, rapidly passes his hand through the air. This causes the "bad air." The victim becomes nervous, dizzy, full of worries. The "doctor" must ascertain from the symptoms in which direction the witch's hand was passed and then applies the "good air" by passing his own hand in the same direction. Or suppose a mother complains to the *albolario* (herbalist) that her daughter, always ready to play, develops headaches and weakness whenever asked to perform any household task. An "Anglo" physician has already examined her and insisted she has no ailment. But the *albolario* learns two things: that someone suspected of having the evil eye had once been friendly to the girl, and that an owl hoots near the house. The illness and its treatment are now clear. A cross of two sticks must be erected outside the house by the mother to ward off the witch, and the girl must be told a witch is after her and might kill her violently if she does not obey her mother promptly. A month later the *albolario* finds the girl happy and well and the mother rejoicing over the cure. Or again, suppose a woman is afflicted with eczema which appeared when she suspected her husband was unduly

interested in another, an Anglicized, woman. The "doctor" (after talking to the wife and other villagers) advises the husband his sweetheart is a witch who has not only made his wife ill but will make him sick very soon, too. He gives the husband an amulet, the wife a sachet. He advises the wife in coquettish techniques, gives her a salve for her skin and a tonic of vitamin B and iron. The patient's marital and physical problems disappear at the same time.

The author contends that the principal difference between concept and treatment of psychosomatic disturbances by *albolarios* and psychiatrists is that the former consider the witch a necessary intermediary bringing person and maladjustment together. The conscientious *albolario* examines his patient's physical condition, emotional state and social background carefully before deciding that witchcraft is the causative factor of the disease. There is also an obvious parallel between the methods of suggestion and reorientation used by the witch doctor and the psychiatrist. The work of the witch doctor also parallels the Catholic confessional: catharsis is offered, and though the terms frustration, complex, and inhibition are not used, their mechanisms are understood and the patient is appropriately manipulated back to health.

BARBARA KELLY

New York, N. Y.

Organic Thinking Difficulty, I. S. Freiman and Paul V. Lemkau, The Journal of Nervous and Mental Disease, Vol. 102, No. 3, March 1946.

The authors present an interesting case of a soldier, who, because of the peculiarities of his thinking disability was termed a malingerer. A thorough neurological and psychiatric investigation performed by the authors, which included encephalography, revealed that the patient suffered from an organic brain disease, probably cerebral atrophy of unknown etiology.

The patient complained of "blind spells" occurring every two or three months without warning. There was no evidence of epilepsy. What baffled and irked the investigations was the patient's constant assertion that he was very "dumb," that he couldn't learn and couldn't read a ruler. However, he admitted that he passed his school grades after having failed only once before reaching the eighth grade. He was a poor student, contrary to his siblings. No childhood diseases. At the age of two he allegedly had an accident, having fallen from a high chair and suffered a "fractured skull." No enuresis, no distinct neurotic traits in childhood.

Patient entered high school, but found the work "too hard" and quit. Also found his various jobs too hard, and after several attempts returned to the job of unloading boxes at a cardboard container factory.

Inducted into the Army in 1943, he was sent overseas after having

finished his basic training. He reported that he could not handle his rifle or his field pack, and always had to be helped by his fellow soldiers; was acutely conscious of his deficiencies. Ten days after arriving in the foreign theatre he was sent for observation. Physical and neurological examination was negative except for hypertension. X-rays of the skull were negative. Mental status revealed an individual who was anxious to impress the examiner with his "dumbness." The discrepancy between school achievement and the patient's evaluation, led the examiners to the impression of an "unwilling soldier," an impression which was supported by various intelligence tests.

Examination carried out by the authors at a later date revealed that the patient, although being able to acquire and remember information, was utterly incapable of combining and integrating the available facts.

The authors explained why the patient was able to go through school: "He always gave an answer, rather pitifully hoping that he guessed right, and thus got credit for trying." The authors described tests by which a thinking difficulty of this type can be diagnosed.

The article is extremely valuable to those who are to make decisions in questions of malingering. A correct diagnosis in a case of this type may enable members of the family, the authorities of a school, or the armed forces, to evaluate the "slowness" of such individuals properly and save them from illtreatment.

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(F) SEXOLOGY

A Psychiatrist Looks at Sex Offenses, Philip Piker, *The Journal of Social Hygiene*, Vol. 33, No. 8, November, 1947.

The author maintains that individually and as a group people do not have a sound and consistent attitude toward sex. The reasons, he says, are partly personal and partly cultural. Children, in passing through the various phases of their sexual development, often arouse the tense concern and the militant prudery of their parents. If adults cause children to develop anxiety and fear during this development, abnormal sex behavior may result. When parents secretively refuse to satisfy a child's innocent curiosity or react with distaste, anger, or punishment, the child grows up to be frigid or impotent, or to have excessive sex desires, or to demonstrate perverted sex interests.

The existence of sex offenders requires two types of social action: first, psychiatric treatment of the individual offenders and second, prevention of future offenders by wholesome sex education of children. It should be stressed that sex offenders are sick people. They are willing to risk imprisonment, bodily injury and death, rejection by friends and family, financial and professional disaster—everything, for the sake of acting out

their sexual needs. Neither coddling them nor jailing them will help either themselves or society. They need treatment, just as typhoid fever victims do. The best practical example of what to do about them is contained in a California law which enables a judge to sentence a convicted sex offender to an indeterminate period of incarceration; the offender goes free when a commission composed of a psychiatrist, a psychologist, a legal authority and some other qualified persons have established that he no longer has his sexual problems. Society is protected; the sex offender is treated and cured.

Immunization of individuals against this type of illness is necessary. The child's natural sexual energy must be channeled into acceptable forms of activity such as physical exercise, hobbies, and intellectual pursuits. If it is repressed it may manifest itself in disguised form as nervous symptoms of emotional maladjustments. If not properly guided it may result in excessive, perverted or overly aggressive sexual behavior. The sexual drive can be integrated as an acceptable part of the total personality of the healthy child. This is the adult's job.

The adult, to achieve the goal, must acquire insight into his own sexual orientation. Distasteful as it may be, he must straighten out his own emotional kinks in order not to infect the child with the germs of sexual maladjustment and emotional illness. He should also bear in mind that just as charges and rumors of sexual offenses are often untrue or exaggerated, so too the child occasionally weaves sexual fabrications into his fantasies and falsehoods.

BARBARA M. KELLY

New York, N. Y.

Remarques sur un cas de depression mélancolique déclanchée par un traumatisme sexuel (Remarks on a case of depression following sexual traumatization), E. Stern (Paris), *Monatsschrift für Psychiatrie und Neurologie*, 113, 1947, No. 6, 377, Basle, Switzerland.

The author reports the case of an 18-year-old boy with a recurrent depression. The first episode began when patient was 16 years old and lasted for about six months. This depression started after the patient was induced to have intercourse with a prostitute while an older man ("voyeur") looked on. The second attack occurred when the patient was 18 years old, after his sister got married and became pregnant.

The author stresses the fact that traumatic sexual experiences may set in motion a depressive psychosis. He states that it is probable that these experiences initiate certain endocrine disturbances which seem to be related to the mechanism of depression. The author discusses further clinical, psychological and criminological aspects of the case.

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(G) SOCIAL HYGIENE

(Abstracted and commented by Barbara M. Kelly, New York, N.Y.)

The excellent publication, "The Journal of Social Hygiene" performs a great service of public enlightenment. In the scope of its work we can recognize two general aspects: (1) Cooperation with public health agencies for disseminating medical information and helping encourage examination and treatment of venereal disease, and (2) working actively for the preservation and stabilization of the American family. The latter task represents the effort of the Social Hygiene movement to attack the venereal disease at its root. The Social Hygiene movement also offers an educational program designed to assisting adults in the sex training of their children. Marriage and family counseling agencies must be set up in adequate numbers and distribution, and manned by a specially trained personnel. The Social Hygiene movement advocates the elimination of prostitution, discourages promiscuity and strives toward an elevation of family life to the highest possible standards by the application of scientific means of research and therapy.

Community Concern for Social Hygiene Futures. Co-operative Efforts Toward Stabilization of Family Life, Mrs. Meredith Nicholson, Jr., The Journal of Social Hygiene, Vol. 33, No. 7, October 1947.

The Army, having reduced its venereal disease rate 30% last year, has now included discussion of moral factors in talks to troops on sexual hygiene. Communities desiring abatement of venereal disease, prostitution and sexual promiscuity must also concern themselves with cultivating a reformation of attitudes toward sex. Health, law enforcement, recreation, housing and education must all be scrutinized to ascertain if they are providing the ultimate in social hygiene.

Have the venereal disease facilities of the war been maintained? Medical treatment, contact-tracing, public relations, and social follow-up are all parts of an adequate health program. Unremitting efforts to abolish commercialized prostitution, protective and preventive police work and correlation of police work with social work are needed.

Are group-work agencies really trying to capture the recreational interests of the least resourceful, most rejected youth of the town? Community planning of wholesome recreation will help prevent young people from seeking the least common denominator of sex in leisure-time activities.

Social climate is largely determined by housing. Rotting floors, lack of plumbing and several people sleeping in one bed make hygiene virtually impossible. It would pay communities in dollars and cents to clean up slum conditions.

An education program should include purveying public health information and providing sex education. The latter does not consist of a pat

formula, a capsule of the "facts of life" but of developing young people's responsibility regarding the social, ethical and eugenic aspects of sex. Instilling in each generation ideals of emotional sincerity and family loyalty is everybody's job—the home, the church, the school, the social agencies. Integration of these separate efforts requires leadership. People who are confident about negative programs of character education must be less timorous about supporting a program of positive emotional development.

The author, who is executive secretary of the Indianapolis Social Hygiene Association, reports that an Institute for Family Life Education has sent ten teams consisting of a parent, an educator and a public health representative, back to their respective communities to provide a nucleus for social hygiene committees. They will work for the stabilization of family life and the development of happier, healthier individuals. It may be hoped that planting the ideals of honor, chastity and self-discipline in the hearts of children will prevent much of the venality of adult life.

Marriage and Divorce in the United States Today; Proceedings of a Session of the New York Regional Conference, American Social Hygiene Association, The Journal of Social Hygiene, Vol. 33, No. 4, April 1947.

Opening the meeting of February 5, 1947, Mr. Reginald E. Gillmor, a member of the ASHA board of directors, recalls the vast discrepancy between our technical and our social skills. Venereal diseases are both cause and result of destructive family conditions. The ASHA has worked for elimination of venereal disease and for better understanding of the causes of family instability.

Carle Clark Zimmerman, Associate Professor of Sociology at Harvard University and author of *The Future of the Family* and *Family and Civilization*, predicts a violent temporary disintegration of the whole family system, the third in Western history. A blackout of Greek and Roman family experiences allows little beneficial comparison with the present. The impending family disintegration is due in the next fifty years.

A study of middle-class divorce novels, such as *Cass Timberlane* and *The Fall of Valor*, indicates a "return to the sanctimony of the family" theme. All evidence is that the middle-class family system has about reached its maximum demoralization and is trying to reformulate itself. Even Ilka Chase's characters are always crying in bed.

By statistical extension predictions have been made that the divorce rate will be one for each marriage in 1975. Zimmerman believes it will be either much better or much worse than that, depending on "the great human masses." Lacking the ethical outlook of the middle class and the ruling class's opportunity to keep up appearances, the masses are heading for

disaster much worse than that of the other two groups. This may be observed in the Supreme Court case of *North Carolina vs. Williams*, 1942-45. There are abundant indications that the American family system will reproduce the Swedish.

What is to be done? First needed is a creative minority who thoroughly understand our family system apart from traditional values. The second requisite is a thorough appreciation of the minds of the three social classes. Then mass moral education should be tried on a wholesale basis, selling civilization on the aspirin level. This might be accomplished by a sermon on each matchbox, expenses borne by industry and responsibility by "Hucksters of Civilization, Inc."

The General Director of the Family Service Association of America, Mr. Frank J. Hertel, introduces the panel discussion with a statement of the family unit as contributing the most to character and personality development and exerting the greatest influence on society as a whole. The present ratio of one divorce to three marriages may be only temporary due to war conditions, but the need for marriage and family counseling will continue to exist. Whose job is this counseling?

Dr. Robert M. Gomberg, Assistant Executive Director of the Jewish Family Service, New York City, speaks of the necessity for proper training of counselors and enunciates four requirements in such training. (1) Thorough psychological, psychiatric, sociological preparation to enable the counselor to differentiate situational from pathological etiology. (2) Understanding of the family as a gestalt. (3) Development of a self-conscious, consistent, scientific method of treatment by on-the-job training under close, controlled supervision as in medical internships. (4) Continuation of such supervision for four or five years after the internship.

Dr. Charles F. Maiden of Rutgers University and the New Jersey Tuberculosis League believes it is possible for public health agencies to perform marriage counseling on an interim basis until the local community recognizes the need for special service by setting up a separate agency, since only public health agencies have the combination of financial ability and lack of "charity" stigma. However, marriage counseling should be conducted only by persons who spend all their time at it and have wide basic training.

From the Philadelphia Marriage Council, Mrs. Emily H. Mudd believes on the contrary that marriage counseling, especially with need for preventive help, should not be limited to any one professional group providing that high professional standards are preserved. What is most needed today is pooling of all kinds of research materials in order to help establish the study of marriage relationships on a scientific level.

The need for competent training in counseling and family relationships in theological seminaries is acute, according to Dr. Robert W. Searle of the

Protestant Council. The clergyman now has intimate contacts with families usually without having developed skill from professional training.

The New York Domestic Relations Court, represented by Judge Theodore Stitt, utilizes every facility of all the city social welfare agencies in an attempt to prevent and correct family problems rather than inflict punishment on suffering individuals.

And finally, Dr. George S. Stevenson of the National Committee for Mental Hygiene emphasizes the need for all service organizations to acquire and utilize counseling skills, since doctors, nurses, social workers, ministers and others have the opportunity to help prevent family disintegration. With other members of the panel, he approves Zimmerman's plan for mass education but warns that if the public is to be sold the idea that there are top-notch counselors available, care must be taken to prevent capitalizations on this salesmanship by unqualified or unscrupulous persons.

(H) SOCIAL PSYCHIATRY

Psychiatry and Social Work, Grete L. Bibring, *Journal of Social Casework*, June 1947, pp. 203-211.

In a very clear and common-sense style Bibring gives a number of good formulations.

Good casework has existed before social workers began to study psychiatry. Many workers did, and still do good work by the use of intuition, which may elude the logical, analytic thinking. But intuition alone is not sufficient because it is dependent on a number of fluctuating factors: our state of mind, our disposition and our emotion. On the other hand, with knowledge alone, understanding will remain exposed to errors of a purely rational approach. Both psychiatrist and social worker should therefore be as completely informed as possible about anything which can promote the understanding of human nature.

The author presents a comparison of the process of psychoanalytic therapy with the process of social casework. The goal of the psychoanalyst is to change the patient's neurotic personality through insight. To obtain the necessary information he uses the method of free association. This technique provides the analyst with the most intimate material, which is then handled technically by interpretation and manipulation. Interpretation refers to the unconscious meaning of thoughts, attitudes, etc. It plays a leading role in analysis. The second technical approach is manipulation of the patient's personality and his relationship to the therapist—the transference—throughout the various changing situations as they arise within the therapeutic process. Manipulation refers to the therapist's attempts to influence the patient in immediate ways, verbal and non-verbal, by making use of his actual or habitual emotional system for the purpose of the cure. Manipulation is a direct method of influence as distinct from

the indirect method of interpretation and insight. Manipulation may be *positive* (trying to achieve certain results) or *negative* (tending to avoid certain complications). The patient may or may not be aware of the manipulation, the latter being more frequently the case. Manipulation may be a personal one (within the therapist-patient relationship) or an environmental one (through suggesting a change in the patient's external circumstances). Manipulation within the therapist-patient relationship is using the patient's confidence in and attachment to the therapist, to help him in giving up his defenses, facing many a painful fact, living through re-activated conflicts, withstanding a temporarily unsettled tense situation and the like. The process of interpretation is intimately linked up with manipulation. Timing and dosing of interpretation are again forms of manipulation. The latter is subordinate to interpretation in that it prepares the way for an efficient interpretation and subsequent "insight."

The goal of psychotherapy is, in a sense, different from that of psychoanalysis. It does not strive for a causal solution of the patient's conflicts or for a basic reorientation of his ego, but for a limited adjustment of the neurotic patient to his own possibilities. This should not be construed to mean that psychotherapy can achieve only that much and not more. Generally speaking, the psychotherapist needs the same basic knowledge as the analyst. He must know the main structure of the patient's symptoms and personality, his essential relations to his environment and his basic conflicts, and must have perhaps a general acquaintance with the most important parts of the patient's infantile background. The psychotherapist gains this knowledge through interview and observation, not by the technique of free association in the strict sense. Psychoanalysis is active in the utilization of the material and in handling various situations, but more expectant in relation to the production of the material. Psychotherapy is active in both respects and much more so than psychoanalysis. The basis of psychotherapy is what we may briefly term as confidence-transference. All types of psychotherapy can be reduced to five groups of technical procedures: suggestion, emotional relief, immediate influence (or manipulation as defined), clarification, interpretation (or insight as defined). The true dynamic nature of the technical procedure is not so much determined by what we actually do, but essentially by the effect it has on the patient, a viewpoint much neglected by many writings on psychotherapy. Unfortunately, the effects of the various therapeutic measures are readily evaluated and explained according to the therapist's theoretical viewpoint and in terms of his favored explanatory scheme without much investigation into their actual dynamic nature. *Interpretation*, though not intended to be "suggestion", often works out as just that, especially in case of brief psychotherapy. In analysis the analyst, as a

matter of principle, tries to avoid suggestion, though in certain cases and situations he may use it quite legitimately. *Emotional relief* refers to all forms of expression, and in subtle ways it seems to be a factor in all kinds of psychotherapy. It is not simply identical with abreaction, but represents a more complex process with various gratifications involved. *Clarification* refers to the establishment of the right perspective; the separation of objective and subjective factors, of actual and personal meaning, of the mature attitudes of the ego and its neurotic conceptions and patterns. It does not (or need not) include unconscious factors. When we convince the patient that his troubles are psychogenic or self-imposed, when he begins to see people in his environment in an objective sense, then we have clarified his relation to himself and others. *Interpretation* as distinguished from *clarification*, refers to the exposition of unconscious dynamic factors. The role in psychotherapy played by interpretation has not yet been definitely clarified, although it has received technical study to a great extent. It is often identical with what we call clarification, which establishes detachment and control. It may often be functionally identified with suggestion. Frequently interpretation in psychotherapy consists in the adequate verbalization of pre-conscious material which the patient himself has not been able to verbalize. Such interpretations are as a rule very effective. In any case, dynamic interpretation (as distinguished from genetic interpretation) is strongly predominant. In psychotherapy then, the widest application is made of immediate influence on emotional systems whether the therapist is aware of it or not.

The situation in *social work* is different from the outset. The client often comes to the agency for reasons other than the need for psychic help. If psychological problems are involved in his difficulty he may or may not know of their existence. Furthermore, the worker does not deal with the client exclusively, but often with his family and his environment. In addition, the worker has to act immediately, because of the specific nature of the client's request. The aim of casework is to help the client find the satisfactory form of social adjustment—on the basis of psychological understanding, frequently through direct help with the social problem. Psychiatric and psychoanalytic literature has recently paid increasing attention to the function of *actuality* in the onset and the development of psychoneuroses. The traditional assumption that among the determinants of a neurosis the infantile predisposition has to be considered as the crucial factor, is now considered valid only to a certain extent. It is a well known fact that change of a real condition of life not only creates neuroses, but also makes neuroses disappear. Such changes need not be of a temporary nature. Favorable experiences in life may result in a lasting "cure" without any treatment of the infantile pre-

disposition. For psychotherapy imitates in a condensed and systematic form the curative conditions of life and achieves similar results in essentially similar ways. This in certain respects is true also of psychoanalysis. We know that the process of the psychoanalytic treatment as well as its results is, to a varying degree, conditioned by actual circumstances. We treat and sometimes cure our patients under practically limited conditions, due to the actual circumstances of the treatment and of life. We attempt to render the patient fit for the average conditions of life; that is conditions favorable to the cure, later, to the maintenance of the result achieved, if conditions remain approximately the same after the treatment. A person cured in this way may later, when exposed to specific traumatic experiences, nevertheless fall back to the former neurosis or develop a new one. In all these problems we are dealing with the dynamic structure of the individual, and that part of his actual environment which represents spheres of mutual influence in the dynamic system of his personality. At whatever point in this system a change takes place, it will exert influence on the rest of it. The treatment of personality disorders can be undertaken from within or from without, or through a combination of both approaches. The *environment approach* is the genuine contribution of casework. From this point of view the problem of what the social worker should know is self-explanatory. His knowledge has to comprise the psychological development of the personality, its main phases and their disturbances, the various outcomes of these disturbances, the different personality types as a result of inner development and outside influence, the main mental mechanisms observed in these different types, the basic sources of conflicts, failures, the main possibilities of success and adjustment, the role of sublimation and transference; in short, the fundamentals of the psychology and psychopathology of the personality. In general, the caseworker will not be called upon to use his impressions for interpretations in the analytic sense of the word. He can effectively interpret the nearly obvious, that "almost" exists in the client's own mind, but for which he has not found a formulation and thus not realized an understanding.

New York, N. Y.

J. WILDER, M.D.

(I) PSYCHOLOGY

How I Chose My Career, Alfred Adler, Individual Psychology Bulletin, Vol. VI, 1st and 2nd Quarters, 1947.

In this original paper, also included in Phyllis Bottome's biography, Adler cites his early childhood memories, which he believes determined

his choice of a career. First, when he was about two years old and crippled with rickets, he saw his elder brother running and jumping. He later did his utmost to excel in physical activities, playing with other children in a vacant lot next door. When he was nearly four years old, his baby brother died. As he did not get along well with his elder brother and felt that his mother had transferred her affection from him to the baby, he sought social satisfaction in games with both boys and girls. Being friendly and lively, he was well received everywhere.

Adler's struggle to overcome his early organic inferiority and his efforts to emulate his elder brother are related to his basic view in *Individual Psychology* that inferiority feeling is the motivating power of the striving for achievement. His early extra-familial social contacts were transmuted into a belief that social feeling should aim at an ideal of perfection for mankind. These experiences also represent his desire to "move freely—to see all psychic manifestations in terms of movement."

Not the experiences themselves, but the manner in which he judged and assimilated them, were important. For example, his parents returned from a few days absence to hear him singing a song about a woman who was too soft-hearted to eat chicken livers but threw everything in reach at her husband's head. The father rightly concluded that the governess had taken Alfred to musical shows in the evenings. The young Adler also looked deeper and learned from the song that people must be judged, not by their spoken words and sentiments, but by their actions.

He reports that he was able to grasp the fact of death "wholesomely" when his baby brother died, but he was nevertheless terrified when he had pneumonia at the age of 5 and heard the doctor tell his father he would die. As soon as he was well, he decided to become a doctor in order to have a better defense against death. He concludes: "I decided at an early age to come into close contact with all difficult problems, in order that I might be in a better position to solve them."

Adler's reference to his wholesome attitude toward death when his baby brother died does not seem to jibe with his envy of the child and his surely relieved feelings that this rival for his mother's affections had been removed. It also seems strange that less than a year later he should have been so terrified by the possibility of his own death that he determined to become a doctor "in order to have a better defense against death."

BARBARA M. KELLY

The Psychiatrist and the Psychologist, Daniel Blain, Chief Neuropsychiatric Division, Veterans Administration, *Journal of Clinical Psychology*, January 1947, Vol. 3, No. 1 (pages 4-10).

In this speech, delivered at the occasion of its first post-war meeting of the American Psychological Association, Blain pointed out that we live at a time when the country is in greater need of psychiatry and psychology than at any time in its history. Still, both sciences behave like a pair of fighting brothers with a similar heritage and comparable functions in the general economy of family life. How can the conflicts be overcome? By centering our attention upon the patient's needs rather than on the needs of psychology or psychiatry as sciences in themselves, isolated from practical purposes. What does one need to know about the patient in order to help him? One must know, what the patient wants. Diagnosis, therapeutics, and management of the environment are the three factors which will help the patient. The qualifications needed for either work are: empathy, training, and rich experience, both in one's own life and in that of the patients. He warned of the "temptation to exercise the authority derived from qualification in one field as justification for doing another sort of work which has become more pleasurable in the meantime, but for which one has not had satisfactory background." Thus a psychologist who takes over the responsibilities of a psychiatrist usually lacks training in pathology, anatomy, and biochemistry; the psychiatrist on the other hand, lacks training in statistics. However, the delegation of duties should rest on the preparation for directing or performing any of these functions. The article closes with a most convincing appeal to research in all fields of neuropsychiatry, but especially in the methods of prevention of mental disease.

EILHARD VON DOMARUS, M.D., Ph.D.

New York, N. Y.

Criteria of Progress in Counseling and Psychotherapy, Ruth Strang, *Journal of Clinical Psychology*, April 1947, Vol. 3, No. 2 (pages 180-183).

The surgeon knows when he has cured his patient. Does the psychotherapist know? Is it not one of the favored objections to psychotherapy that the "talking-to" can have no tangible results? The author tackles this moot question and gives the following possible five criteria of progress. (1) Non-return to treatment (this is rejected as proper criterion, because it can also mean unsuccessful treatment). (2) Non-return for treatment plus evidence of vocational adjustment, including the development of adult "friendship technics." (3) Cessation or reduction of symptoms, e.g., reduction of morbidly aggressive behavior. (4) Patient's own feelings, expressed during and after treatment, that

they have been helped by the therapy. (5) Evidence of adjustment to life; e.g., more remunerative post-therapeutic gainful occupations. There is a great need for systematic study of the patient before, during, and after psychotherapy in order to determine progress made in a reliable, precise manner.

EILHARD VON DOMARUS, M.D., Ph.D.

New York, N. Y.

A Review of Physiological and Psychological Studies of Sexual Behavior in Mammals, Frank A. Beach, *Physiological Reviews*, 27: 240, 1947.

This critical review of available data in the field of sexual behavior in mammals deserves full attention of the psychotherapist. It is important to realize how many behavior patterns which we usually attribute to complicated psychological mechanisms of high order can be found on lower levels of psychological functioning in animals.

The author using a holistic approach discusses (A) the neurological (B) the behavioral and (C) the hormonal data.

(A) *Neurological evidence* reveals that many of the discrete sensory-motor components of the complete copulatory pattern are mediated by spinal reflexes; various genital reflexes as well as coital postures survive in spinal preparations. Of course, higher centers exert inhibiting and facilitating influences and integrate these reflexes into a biologically effective behavior pattern. In rodents, lagomorphs and carnivores those supra-spinal mechanisms seem localized somewhere between the spinal cord and cerebrum, perhaps in the hypothalamus. Decerebrate females of the species mentioned can mate. This is somewhat different in males: here nothing is known about analogous supra-spinal mechanisms. In male rodents decerebration abolishes sexual arousal despite the fact that the cortex plays no essential part in the motor organization of the copulatory act. The male cat in contrast to the female shows no sexual response after decortication. Nothing is known in this respect about monkeys. While the role of genital stimulation is well understood this is not true for pre-contact arousal. Females of several subprimate species copulate after combined removal of organs of vision, hearing and smell; they still respond to direct bodily contact. Sexual arousal in males of lower mammal species does not depend on any single cue but on a pattern of simultaneous and repetitive stimulation of several receptor systems. The latter seems true for primates of either sex.

Interesting for the psychologist are the following details: the extreme individual differences in sexual responses exist in male rats (normal and castrated), boars, monkeys, etc. The more sexually excitable the individual animal is, the less specific are the sexual stimuli to which he responds (non-receptive females, other males). These individual differ-

ences are much greater in the male than in the female. They consist also in extreme differences in the amount of sexual stimulation necessary for the ejaculation, e.g., for the rhesus monkey between 3 and 100 thrusts. Related to this may be the fact that some male chimpanzees react to the female abruptly, indulge in little or no foreplay and copulate violently, while others practice a great deal of foreplay, copulate only after considerable preparation and treat the partner gently. In receptive females extra-genital stimulation even if only mimicked by the experimenter provokes sexual behavior. The pre-coital stimulation in various species consist in touch, biting, nibbling various parts of the female body, sucking or biting the female's ears; sometimes even aggression and injury are observed. However, in contrast to man, there is little evidence that the breast is an erotic zone. All this is true for the female; there is also very little evidence to the effect that extra-genital stimulation is important in the male. Sensations from the genital region are not essential for the mating behavior of the female, which persists after elimination of these stimuli. That does not mean that genital stimulation, manual and oral, is not being effectively used for that purpose in mammals, especially in monkeys. The same is true for the male genital. Female chimpanzees may induce erection in the male by manipulation of the flaccid penis. Genital reflexes occur, though, in many species without external stimulation, in sleep; in male bats during hibernation, in form of erection and copulatory movements.

The author describes the main motor patterns of copulation and stresses the surprising degree of adaptability under experimental conditions. Thus, e.g., chimpanzees may assume the ventro position. Since spinal mechanisms are responsible for certain genital reflexes (erection of the clitoris, etc.) it is not surprising to find it in animals and man shortly after birth. It is well known that masturbatory manipulation by man with severed spinal cord produces coital motor patterns, despite absence of sensation. The sympathetic nervous system seems to be essential for ejaculation only. In the sympathectomized rabbit this leads to persistent copulatory acts without ejaculation up to the point of complete exhaustion. Decorticated female rats show estrus reaction but exhibit no tendency to direct that behavior toward the male; in the male rat removal of at least 60-75% of the cortex is necessary for elimination of copulation. Male cats with certain types of cortical injury show disturbances of sensori-motor coordination leading to inaccurate and abortive mating acts. The cortex seems more important in carnivorous beings than in rodents and has perhaps a facilitating effect on the lower sex centers. Too little is known about the primates. Going through various species from fish to mammals it is fair to assume that the evolutionary trend is toward increasing role of the younger parts of the

central nervous system in courtships and mating. Parallel with this development we observe: (1) a greater variety of external stimuli evoking sexual responses; (2) a greater variety of patterns of sexual expression; (3) decreasing importance of gonadal hormones.

(B) *Behavioral evidence* is supplied by laboratory experiments, animal breeders, etc. Analogies with human sex behavior are self-evident. In many species there is a close relationship between sexual and other excitement. Sexual responses tend to appear in highly emotional non-sexual situations, or sexual arousal is inhibited by fear. Interesting differences between sexes can be observed: in the male, sexual arousal is often inhibited by a strange environment or by familiar environment previously associated with painful stimuli; these phenomena are much less frequent in the female.

A familiar environment associated with memories of previous copulation has a facilitating effect in the male only. Once sexually aroused, the male becomes unresponsive to external non-sexual stimuli, while the female can copulate and simultaneously take care of other things. Another intersexual difference exists in subprimate species inasmuch as the male shows some, although incomplete, copulatory responses long before puberty, the female only with the first estrus. These observations show, in accordance with the neurological evidence, that the male's sexual behavior is more intimately influenced by the cerebral cortex. In primates and humans both sexes indulge frequently in pre-puberal sex play, which in children and chimpanzees may be carried to the point of heterosexual intromission and pelvic thrusts. This too the author accounts for on the behavior is more intimately influenced by the cerebral cortex. In primates the inexperienced female reacts correctly to the male's copulatory attempts while the inexperienced male has to go through a long period of learning. In primate as well as sub-primate species the female in heat may mount other females and behave in a masculine fashion, while males may behave in a feminine pattern in response to advances of other males. However, when heterosexual stimuli are offered they return to their normal pattern. Thus it seems that the neuro-muscular sex pattern is genetically bi-sexual, and distorted only by structural and functional limitations. Concerning auto-manipulation it is pre- and intercopulatory only in sub-primates; in primates it occurs in various situations and may be carried to the point of orgasm. Masturbation in man would thus correspond to a higher degree of evolution.

Erection and ejaculation in dogs and chimpanzees was observed under influence of fear, presentation of food, disciplinary measures; in children genital reflexes may appear on painful stimuli, in pre-adolescent boys when they were frightened. Immature chimpanzees masturbate when angry, cebus monkeys and apes when facing a difficult learning

problem, children during a class-room examination. Male rats subjected to electric shock during copulation become inhibited during the subsequent tests; however, if exposed to electro-shock just before or during presentation of a female, they copulate even during the shock.

For the free-ranging rhesus a new female has a greater stimulus-value than one to which he is used. Male rats with underdeveloped penes get highly excited as a result of unsuccessful copulations and attack the female much more frequently than the normal rat; female rats in cases of many unsuccessful copulations may launch vicious attacks upon the male. One male macaque failing to achieve intromission despite all help by the female began to bite his feet severely, and thereafter the mere appearance of a female threw him into a frenzy of self-mutilation. Because of adverse reaction of the male to new surroundings, in contrast to the female, commercial breeders take the estrous female to the male's cage since in the reverse case the male wastes much time exploring the cage, etc. The estrous bitch can eat, the estrous cat may explore a mouse-hole during coition; this has never been observed in the male. A stallion which has mated with dark mares exclusively does not mount a white one. A cage in which copulation has taken place repeatedly, acquires for the male sex-stimulating qualities, and male rabbits in such a setting will mount cats, kittens, guinea pigs and even dead and inanimate objects. Experiences accompanying the first complete sexual intercourse exert a powerful influence upon subsequent responsiveness, e.g., when a fight occurs in the first contact the male mink shows little aggressiveness later.

The intersexual differences concerning pre-puberal sex play are due not only to neural but also to hormonal factors: the interstitial tissue of the testis matures and functions earlier than its ovarian counterpart. While the inexperienced male chimpanzee often fails to achieve intromission and ejaculation, the female's responses are adequate even the first time and may include manual introduction of the penis into the vagina. The "feral" man (Kaspar Hauser, etc.) also showed a very low sex drive. Feminine behavior in males is less frequent than masculine behavior in females. Male rats with occasional feminine behavior prove to be unusually vigorous copulators when placed with females. The conclusion is that this feminine behavior appears at high level of sexuality when heterosexual contact is prevented, e.g., in castrated rats injected with high doses of androgen. The masculine pattern in females is evoked by the same stimuli which evoke it in males and vice-versa.

Masturbation occurs in male monkeys years before ejaculation is possible and in adult males despite free access to the female. Both sexes, especially the female, use various objects for masturbation. It has been suggested that erections of penis and clitoris observed in primates and man, as well as motor sex patterns in subprimates, occurring shortly after birth,

are due to temporarily surviving maternal hormones. (This reviewer asks himself whether this would not introduce a new factor into the concept of the "trauma of birth.")

(c) *Hormonal evidence.* It is known that in the seasonally breeding species the sexual performance in both sexes coincides with the waves of internal secretion. In year-round breeders this is true for the female only. However, in primates a certain degree of emancipation from the hormonal cycles can be observed, even in the female. This points to a progressive emancipation from the hormonal and increasing dependence on nervous mechanisms. The same can be seen in the influence of castration on the sex behavior of various species, and of replacement therapy. In human females, e.g., the effect of both on the libido becomes unpredictable. Males show even a greater hormonal independence than females in all species. Copulation with intromission may survive indefinitely in castrated male chimpanzees, but ejaculation is possible only with the use of androgen. It is well known that the castrated man may preserve his potentia coeundi for decades.

In the male rat under the influence of castration the feminine mating reactions disappear within a week, the masculine only gradually. Both patterns are restored by androgen injections, but both may become intensified also by estrogenic treatment. This throws some light on the failure of androgen therapy in male homosexuals; this treatment often leads to an increase of homosexual activity. In human hermaphrodites the preferred sex pattern is determined not by morphology but by upbringing. In human homosexuals the "M-F" test (Terman-Miles) of masculinity-femininity in many cases is contrary to the biological sex. The majority of authors assume that hormones act only as sensitizers for the neural mechanisms.

From these data the author concludes that the following evolutionary trends are in evidence: (1) progressive encephalization of sensory-motor functions including those of mating and courtship; (2) progressive dependence of subcerebral mechanisms upon facilitating impulses of higher centers; (3) increasing variability and modifiability of sex stimuli as well as responses; (4) progressive emancipation from the sex hormones.

This reviewer thinks that the assumption of the facilitating rather than inhibiting role of the higher nerve centers deserves the special attention of the psychiatrist.

JOSEPH WILDER, M.D.

New York, N. Y.

Existe-t-il un rapport entre la date de naissance et le développement mental ultérieur de l'enfant?—(Données statistiques). Travail de la Consultation de neuro-endocrinologie infantile. Directeur: Professeur L. Cornil, Marseille (Is there any relation between date of birth and

mental development in the child?) M. Schachter et S. Cotte (Marseille), *Monatsschrift für Psychiatrie und Neurologie*, Basle, Switzerland, 113. 1947. No. 6, 391.

The authors made a statistical study of 2385 cases, aged 3 to 18. Their investigation concerns the problem of the relationship of the month of birth to the future mental development of the child. The authors used the Binet-Simon intelligence test and classified their groups as follows: 575 mental defectives, 789 defective delinquents, 499 delinquents of normal intelligence and 522 medical students (test objects).

The authors came to the conclusion that the month of birth is quite unrelated to the development of the child's intelligence.

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(J) MILITARY PSYCHIATRY

The Problems of the Occupation Soldier, Dora Jane Hamblin, The Journal of Social Hygiene, Vol. 33, No. 8, November, 1947.

This overseas Red Cross worker reports that two new "occupation" types of casework have developed in recent months, involving the teenage soldier who tries to prove he is grown up and the combat veteran who suddenly realizes that his hasty reenlistment has provided no solution to his home problems.

Some of the young soldiers are the "problem children" of the early part of the war. Some of them assert their independence by failing to write home. Some end in stockades for being drunk and disorderly, or in hospitals with venereal disease. They afterwards waiver between pride in their "adult" accomplishments and shame for deviating from their moral standards. Often they demand that the Red Cross worker fabricate explanations to their families of why they are in the hospital—a jeep accident, for example, instead of the real reason, venereal infection. Some develop extravagant guilt feelings, ascribing the death of a brother in an accident or of a sister in childbirth to their contraction of venereal disease. Hospital workers find these youngsters very hard to work with until they decide to talk things over; then they surrender their problems completely, frightened and ashamed.

There are more and more cases involving older men who re-enlisted because their wives were unfaithful or their marriages unsuccessful. The caseworkers attempt to help the servicemen realize their flight is no solution to their problems; dependency discharges, state-side duty assignments and bringing the wives overseas are some of the steps taken to help these men make a better adjustment.

The writer believes that the incidence of cases involving these older men will eventually decline as fewer soldiers will try to postpone or run away from their problems. But the rising case figure on teen-agers causes less optimism, because the red tape, restlessness and excessive spare-time of occupation duty seem to be particularly hard for youngsters to deal with.

BARBARA M. KELLY

New York, N. Y.

Venereal Disease Anxiety Among Soldiers, Morris A. Wessel, M.C., and Bernard D. Pinck, M.C., *The Journal of Social Hygiene*, Vol. 33, No. 8, November, 1947.

In the Army's 121st General Hospital, serving troops in the Bremen Enclave, the authors had the opportunity to observe a large number of patients with a dominant fear—that they had a venereal disease. About one-half of the patients were treated for v.d. in the urology clinic within the preceding year, but none showed any evidence of infection at the time of this examination. Some 30 per cent of the neuropsychiatric patients and 50 per cent of the urology clinic patients suffered from this type of anxiety, and all were treated concurrently in both clinics. Most of the patients under discussion were about to be deployed to the U.S., either for discharge or for further medical treatment in the States.

Because of a lack of precise knowledge about it, v.d. always predisposes patients to apprehension and anxiety. The fears of familial and public condemnation and of permanent physical disability or inheritable stigmatizing scars are often of clinical intensity under benign conditions. Overseas, the usual stigma is reduced to a minimum, due to the "line of duty—yes" status accepted by the Army, but when patients are on their way home they begin to measure their past conduct by home standards. Will future sexual functions be impaired? Will the folks at home be able to "tell" that the patients had sexual experiences overseas?

Promiscuity overseas results from a lack of restraining influences, of family and community disfavor plus an assortment of stimuli such as boredom, loneliness, bad news, maladjustments and army routine, etc. Aggravating the problem are restlessness under service conditions continued after the end of hostilities, and the overwhelming sexual avidity of a large portion of the female populations. Army life intensifies emotional instability, and experience at this hospital indicates that soldiers' promiscuity is not entirely personality-determined. In fact, it is considered "culturally normal" for them to seek occasional heterosexual contacts.

The homeward-bound soldier in the staging area engages in much introspection. If his appraisal of his military life fails to jibe with the standards of his civilian life and is further exacerbated by uncertainty or unwillingness to assume civilian responsibilities, his dissatisfaction may express itself in worries over his physical condition. If he is eager to get home, he may magnify his past indiscretions in the fear that they will delay or prevent his departure.

Patients with venereal disease anxiety were found to be classifiable into four main categories:

(1) The largest group consisted of those who frequently deviated from their previous moral standards and were overwhelmed with feelings of guilt. Many had been treated for venereal disease previously, and suffered a minimal emotional feeling at the time. They seemed mostly concerned with disease-identifying scars, and some had bizarre somatic complaints. Usually, however, they admitted that their genital complaints were fictitious. They insisted on unwinding long lurid tales to the doctor, who obtained best results by permitting the verbal ventilation. The majority obtained sufficient insight to reduce their symptoms by a marked degree.

(2) "Single offense" patients from rigidly moral home environments came under another category. Their remorse was quickly projected as bodily complaints which they assumed to be compatible with a venereal disease. Their anxiety proved to be deep-seated, progressive, often of an obsessive-compulsive type, and could lead to reactive depression. Psychiatric treatment dominated the therapy. Often hospitalization becomes necessary in these cases.

(3) Patients who exhibited physical signs immediately suggestive of gonorrhea or syphilis, such as penile lesions, urethral discharges, scabies, etc., persisted in their fear of v.d. until a regression of physical signs helped them to accept professional opinion. They frequently applied their own remedies, thus prolonging and aggravating the symptoms. They habituated the urology clinic and usually acquired 20 or 30 laboratory reports from every dispensary in the vicinity.

(4) A small group of patients, whose problems were invariably solved in one visit to a doctor, were beset by non-existent lesions. They were in a hurry to get home and feared that an irregularity in the glands was a chancre or that urine in the urethra after micturation was a urethral exudate, etc.

The chief complaint of patients appearing at the neuro-psychiatric clinic is usually verbalized as follows: "I know I must have something wrong . . . some venereal disease. I have pains in my groin. I can't sleep. I have a slight discharge and my back aches." Examination re-

veals tenseness, anxiety, deep-seated guilt feelings, and no evidence of venereal disease. Two cases of psychotic nature have been observed and many patients have been hospitalized.

The aim of treatment is to instil confidence, give insight and motivate patients to accept going home and facing their families. Treatment consists of complete physical and laboratory examination, discussion of problems and attitudes of soldiers overseas and the relative incidence of promiscuity, and later specific encouragement to go home with their redeploying units.

Hospitalized patients are drawn into an active craft and recreation program. This is doubly important therapeutically because of their acceptance by nurses and Red Cross workers, representative American girls in whose presence the patients initially feel deeply ashamed and reserved. Some patients receive sub-shock insulin therapy which serves as an appetite stimulant. Group therapy in which physical aspects of anxiety and etiological factors are discussed assist patients to gain insight and collective security; this was especially valuable when there were combat men in the group.

Case material is cited in support of the general description of "venereal disease anxiety" and of the classification of cases.

BARBARA M. KELLY

New York, N. Y.

Malingering: Case report—"Proof positive," Abraham Kaplan, The Journal of Nervous and Mental Disease, Vol. 106, No. 1, July 1947.

A case of malingering with "proof positive" is reported to illustrate that it may coexist in a patient with an organic lesion. The 20-year-old soldier had sustained laceration of the right side of the head during an explosion. There was a small depressed fracture of the right frontal bone. Neurological examination was negative. Nine months after discharge patient came back to the hospital with the complaint of headaches, dizziness and episodes of nausea. Soon he was discharged again, since there were no objective findings. He came back again, however, after two months, but this time he was dragging the right leg and complained of weakness, pain and swelling of the right hand. His fingers were edematous to about three times the normal size. After repeated examination it seemed inconceivable that an organic lesion could explain the findings. The Rorschach test gave the impression that the patient was concealing something detrimental to him. It was generally agreed that the patient exhibited a conversion hysteria. Finally, one day it was detected that the patient wore a constricting rubber tourniquet underneath the rolled-up pajama sleeve. The patient could walk properly again and the swelling subsided soon.

thereafter. He confessed that he was afraid of having to leave the hospital and hunt for a job, and that he, therefore, feigned illness and incapacitation.

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PSYCHIATRY AND LAW

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Medico-Legal Problems of Alcoholism, Lyman C. Duryea, M.D., The Record of the Association of the Bar of the City of New York; Vol. 3, No. 1, 1948.

The Bar Association's Committee on Medical Jurisprudence requested Dr. Duryea to prepare a study of the legal problems involved in the control of alcoholism, a subject which the Committee has under study.

Duryea submits that there is no evidence that excessive drinking has been diminished by the punitive approach as a solution of this problem. In effect, laws governing alcoholism give no practical consideration to the alcoholic individual. There should be a legal differentiation between intoxication *per se* and compulsive drinking. Chronic alcoholism is an illness and care for these cases should not be centered in correctional institutions but should be under medical supervision. Psychiatric court examinations should be provided to determine the type of alcoholism and within the structure of the courts special alcoholic parts should be established to make possible an intelligent handling of the large number of alcoholics now appearing before the courts and crowding the jails.

It is suggested that laws be enacted to deal with the handling, care and treatment of alcoholics. Certain recodification is needed, designating the alcoholic a sick person rather than a criminal, and all descriptive terms should have a medical rather than a punitive connotation.

Duryea ends his report in a series of rhetorical questions. These questions constitute a challenge to the leaders of the bar of the largest city in the world to remedy the existing chaotic condition of the law dealing with this subject. So influential an organization can accomplish much in this field. Our own Association avidly awaits developments.

The Lawyer and the Psychiatrist, Eugene Kahn, Connecticut Bar Journal, April, 1947, Vol. 21, No. 2, Page 112.

Kahn observes: "There are no professions that see more people in their moral underwear than *ours*." . . . "The lawyer is a layman in psychiatry, the psychiatrist is a layman in jurisprudence."

Kahn remonstrates that psychiatrists are used as "technicians" by lawyers, that the psychiatrist is "hired" to testify for his client and that the psychiatrist is required to violate his relationship of confidence with his patient by testifying in the courtroom.

He finds a distinct clash between the approach of the psychiatrist and the approach of the lawyer in their attempts to understand human beings. While he admits that "judges and lawyers are working in a venerable framework which under somehow normal . . . conditions changes slowly," he complains that "the thinking of our professions are different."

This reviewer takes issue with Kahn. Of course, there is a difference between the professions. The lawyer is an advocate who uses the tools with which he is supplied, and he does the best job he can with those tools, depending upon his skill. True, the psychiatrist is a "technician." But, if the psychiatrist cannot be "hired," if he adheres to an objective scientific position as dictated by his own profession and refuses to be bound by outmoded and unscientific concepts which are part of the law, the "venerable framework" will accept "the thinking" of the scientist. The thinking of the professions is not different. It is the psychiatrist who betrays his scientific thinking by attempting to fit it into outmoded concepts of law. Psychiatrists are responsible in a great measure for the condition of which Dr. Kahn complains, it is from them that the impulse toward improvement must originate.

Converting the Arsonists, Herman H. Cohn, *The Journal of Criminal Law and Criminology*, Vol. XXXVIII, No. 3, 1947.

Cohn has the misfortune of not only being a lawyer, but also of being advisor to the Illinois State Fire Marshall. It is, therefore, not surprising that his approach to his subject is that of the overzealous prosecutor. He speaks of the psychological background of the arsonist and mental examinations. Yet, his interest in these subjects is based primarily upon using the knowledge gained therefrom for obtaining convictions and not toward assisting the wrongdoer psychologically. Cohn's own words sufficiently characterize his approach. The arsonist is "the fiend who is willing to destroy property and even human beings to carry out his dastardly deeds." The cure? "With the help of competent arson investigators traveling will be easier."

An Attempt at a Revaluation of Some Concepts of Law and Psychiatry, Benjamin Karpman, *The Journal of Criminal Law and Criminology*, Vol. XXXVIII, No. 3, 1947.

This paper is of such importance that it warrants deep consideration by all students of the psychiatric-legal field.

Karpman, with eyes awakened to realities, accepts the unbridged chasm

between the law and psychiatry in dealing with crime. Karpman appeals to both professions for a better rapprochement.

He skillfully argues that a criminal should be charged on the basis of the executed criminal intent rather than on the size of the crime. He recognizes that, in the law, intent is weighed but less emphasized than the degree and graduations of the crime. He demonstrates the impropriety of the existing legal approach by forceful examples. A man steals a case of whisky valued at \$65.00 and is charged with grand larceny, a felony. The defense consists of proving the value of the whisky at \$48.00. Bringing the sum involved to the lower amount, makes the crime a misdemeanor. Again, A fires several shots at B, with the intent of killing him. B is wounded. A is charged with felonious assault.

One pauses to ask oneself—is the thief less a thief because of the value of the whisky; is A less a murderer because by sheer accident he failed of his purpose?

Karpman argues that the present system is in the nature of a palliative; that the criminal deed is the surface expression of a large number of factors, for the most part internal; that the crime cannot be understood unless the psychology of the doer is understood; and that to cure crime, the deed must be reached through the doer.

He courageously shows how outmoded the concept of "let the punishment fit the crime" is. Dr. Karpman makes the flat assertion that from the psychiatrist's viewpoint, "it is not sufficient to say that the defendant knows or does not know the difference between right and wrong." The test should be, he says, "whether he can choose emotionally right from wrong; why, and to what extent he is guilty and to what extent he is responsible." He submits that the correct formula is "let the punishment fit the criminal" or, better still, "let the treatment fit the criminal."

This reviewer commends this position to all psychiatrists who apply their talents to forensics. This position, if adhered to, might bring about a change in the law in respect to psychiatry and silence certain critics of the law.

Karpman is no starry-eyed dreamer. He recognizes that certain crimes are committed on a predatory basis and he labels those doers as "psychopathic"; those perpetrators of crimes who reveal definite psychological causes which are deeply tied with their emotional life are labeled as "psychogenic."

He admits that the psychopathic cases presently are not approachable by psychotherapy. He feels that means should be devised for the psychogenic group to be treated psychotherapeutically. Karpman submits that if criminals are to be treated effectively, they must be treated individually on the basis of their personality as a whole.

FOREIGN

ABSTRACTS FROM BRITISH LITERATURE

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PRESENT TRENDS OF PSYCHOTHERAPY IN GREAT BRITAIN

The application of narcotic drugs in the course of the psychotherapeutic approach—described by Horsley—has been taken up by a large number of psychiatrists in the United Kingdom. There are hospitals where almost every new patient is subjected to exploratory narcoanalysis; and it is only intelligible that particularly young psychiatrists, not yet experienced in the psychological treatment of a large variety of patients, avail themselves of this convenient technique. Whilst satisfactory results are attained in a substantial number of cases, it must become increasingly obvious that the intuitive approach—based on rich experience—without the help of narcotic drugs, remains the more promising method, diagnostic and therapeutic, in an equally large number of cases. This art, however, has at present, very few representatives. Training in it as well as in active dream interpretation is rather a rarity. The large majority of those who analyze without narcosis prefer the lengthy method of orthodox psychoanalysis; and even many of those who on ideological or scientific grounds consider themselves non-Freudians seem to approve of long treatments. It appears that this appeals to the average British individual who is of a patient and rather leisurely disposition, even when he is psychoneurotic.

In some hospitals (for instance at Bart's), pentothal is frequently used to differentiate between endogenous depression and conditions of similar coloring based on anxiety hysteria. Experience shows that under the influence of the drug the essential character of the condition reveals itself.

The physical approach to psychoneurotic phenomena, as for instance favored at the Sutton Emergency Hospital (from where one of the following publications comes) represents a more spectacular and largely original research. Ether abreaction, and the simultaneous employment of pentothal and methedrin intravenously appear to have opened new avenues in rational psychotherapy. It is, however, very probable that the cases in need of these methods are to varying extents different in character from those where pure analytical approach and active psychotherapy are indicated. No doubt, there are chronic cases with definite psychogenesis, where physical methods, as e.g., ether abreaction, are needed to disrupt the pathological pattern of function; and, on the other hand, there are cases, even longstanding, where the employment of narcotic drugs brings

no advantage, and only the shrewd guesses and active approach by the therapist result in appreciable progress.

Group psychotherapy, primarily introduced in the U.S.A., seems to have become the object of more intense interest and research in this country. Treatments are carried out in small or in larger groups which are either closed, or open to new members when some of the original ones leave the circle. The leading worker is Dr. J. Bierer, who, with the help of fellow psychiatrists and social workers has founded psychotherapeutic clubs. There patients discharged from mental hospitals, or from psychological treatment, as well as patients awaiting their turn on the waiting list for treatment gather and participate in a variety of activities. Another piece of Bierer's efforts is illustrated by one of the publications reviewed here. It deals with a service to groups of psychiatrists through making available to them recorded interviews and therapeutic sessions.

ABSTRACTS

Excitatory Abreaction, H. J. Shorvon and William Sargant, The Journal of Mental Science, Vol. XCIII, October 1947, pp. 710-732.

The authors base their explanation of *abreaction* on Pavlov's work. In 1924 many of Pavlov's dogs were nearly drowned in the Leningrad floods. When rescued, some were in a state of acute excitement, which was succeeded by a phase of "collapse" or stupor. This experience had destroyed a series of conditioned reflexes acquired during months of patient work. Other more stable dogs were less affected, did not exhibit the marked excitatory and inhibitory phenomena, and did not lose conditioned responses. The stupor following excitement is, in Pavlov's terminology, called "ultraparadoxical cortical inhibition," and the authors refer to a similar phenomenon in the course of drug excitation as "transmarginal inhibition."

In abreacting patients with ether the authors observed obvious differences from the responses of patients who were treated with barbiturates. Ether produced much more easily and in a far greater degree excitation, and this was followed by a state of "collapse" more frequently than in abreaction under hypnosis or barbiturates. It appeared to the authors that this state of post-excitatory stupor is essential for the full therapeutic result. During abreaction the patients reached a pitch of terror, anger, excitement, and then suddenly lay motionless, unaffected by stimuli, for a minute or two. "On coming round they would often burst into a flood of tears, or state that the outstanding symptom had gone." In many cases repetition of the procedure proved necessary, in particular when the phase of postexcitatory inhibition did not occur.

"Ether proved useful for cases where the abnormal condition had become organized and fixed and had taken on the quality of a stereotypy which needed less and less work to sustain it." "Such conditions often became

chronic, disabling, persistent, and resistant to simpler measures." "It was in patients with good previous personalities showing more chronic hysterical reactions that ether was found more useful than barbiturates. Such patients were treated at a stage when excitement had given place to lethargy, and neurotic patterns had started to become stabilized."

Such was the case of a 47-year-old male whose hand began to shake after a flying bomb accident. For five months he attended hospital daily for a massage, hot and cold baths, and rug-making in the occupational department. For a considerable time his hand was put in plaster. In cold weather the hand became black and blue. Abreaction with sodium amytal was carried out twice; but the result was not satisfactory. On admission to Sutton Emergency Hospital—where the authors work—the hand showed gross tremor, was cold, congested, and bluish red in color. The patient could adduct and oppose his fingers and thumb, but was unable to grip, and voluntary movement caused an extreme increase in tremor. He had a dilapidated, run-down appearance, was mildly depressed and querulous, and complained of blurring vision. Two abreactions only were required until recovery.

Even though one has to try to abreact over the trauma which has precipitated the break-down, there are cases where any artificial creation of excitement (the description of invented situations or other palpably false suggestions by the physician) may bring about the effect necessary for the subsequent "collapse." Interesting is the brief report of a case of de-personalization, the symptoms of which were resolved by an ether excitation when other treatments (E.C.T., psychotherapy, benzedrine, sedation, and insulin) had failed; the incident employed to arouse the necessary excitement was the patient's experience of a mental hospital during the course of his illness.

Repeated abreactions under ether (four or five have been often given about the same remembered incident) may be necessary in reactively depressed patients, or those showing a general state of inhibition following an accumulation of stresses or blast. These patients may require only a simple re-excitation to break through inhibition, and do not always need the culminating transmarginal inhibition that is helpful in the motor or sensory stereotypes. In some cases intravenous sodium amytal leads to the mobilization of aggressive potentials, and going over the same ground with ether releases great excitement and produces the desired therapeutic result. Amnesias are, as a rule, lifted by barbiturates, but in rare cases, where this fails, ether may disrupt the resistance.

Endogenous depressives can only rarely be made to release emotion under ether; "a dull recital of events is often the only result." E.C.T. is the proper means of stimulation in such patients "who are generally stable personalities in a state of profound wide-spread inhibition." "The dis-

ruptive stimulus of E.C.T. may prove too much for the less stable nervous system showing hysterical and reactive depressive features." Yet, "ether can be too disruptive for the chronic constitutional hysterical personality." "They rapidly become inhibited or dissociated under ether. As with Pavlov's weaker dogs, they show chaotic cortical function or total inhibition again and again, following slight excitation." "Benefit from ether is confined to the previously stable person who developed hysterical symptoms following severe stress."

"One is tempted to search for an explanation of differences in action of E.C.T. and ether abreaction". . . "One can but speculate on whether the action of ether abreaction is more cortical, whereas E.C.T. acts more powerfully on the whole brain and particularly the autonomic nervous system. Whatever the explanation, it is significant that abreaction, E.C.T., and insulin are treatments which, at different levels of nervous activity, produce their best by an initial excitation carried to the point of temporary cortical inhibition." "In our experience the best results from E.C.T. generally occur in those showing the profoundest relaxation after the fits. Likewise, E.C.T. given under insulin sopor may sometimes produce better results than E.C.T. alone, perhaps due to the greater final relaxation obtained in this manner."

The method was tried in a small number of chronic obsessional neuroses, in the hope to disrupt the pattern of rumination and fear by excitation and transmarginal inhibition. There were no successes. It is difficult to excite such patients.

If, however, they do become excited, they may be temporarily worse by the abreaction. One may assume that there is in such cases "an abnormal predominance of the excitatory process, an abnormal inertness or pathological inertness in points or areas of the cortex". . . "When there is a useful response to abreaction there are generally hysterical or reactive depressive components to the total picture, or an accompanying state of depersonalization; all of these suggest the presence of inhibitory phenomena which excitation under ether may loosen." Only on one occasion in the series of several hundred treatments did ether abreaction precipitate a temporary psychotic episode. This possibility must therefore be kept in mind.

The details of the technique, as well as the description of thirteen illustrative cases, must be studied in the original publication.

Bodily Changes during Abreaction, R. L. Moody, The Lancet, June 19, 1948, page 964.

The brief report on a case is a postscript to the publication of another case (Lancet, 1946, ii, 934) where rope marks on the forearm of a patient developed during the abreaction of an incident that had happened ten

years before. In the present instance a married woman in her thirties was treated because of persistent insomnia. She had had a very unhappy childhood, and at seventeen she was treated for a "nervous break-down"; after recovery from this condition she seems to have had a wide-spread amnesia for the unpleasant events of earlier periods. During her recent treatment a number of dramatic events were recollected, and on thirty occasions swelling, bruising, and bleeding appeared as "somatic repetitions" of what presumably had been originally traumatic injuries by a cruel father or through accidents. For instance, after abreacting an incident in which she had been thrashed with a cutting whip at the age of eight years, three large bruises appeared on her left buttock. Or, a few minutes after abreacting an incident in which she had cut herself by rushing through a window, long red streaks appeared down her leg. The patient reported that these bled during the following night.

The Recording of Psychotherapeutic Sessions, Its Value in Teaching, Research, and Treatment, J. Bierer and R. Strom-Olsen, *The Lancet*, June 19, 1948, pp. 957-958.

The teaching of psychotherapy has always been difficult. Training analysis is a good but expensive and lengthy means of being acquainted with the task. "Even if the psychotherapist has been through a long analysis, it does not follow that he is qualified to use a short-term method of psychotherapy. Some will gain extra insight and therefore will be able to use short methods; but others will be more loath to use any other method than that which they have learnt themselves." (In some instances it appears that the analyst has transferred substantial narcissistic libidinal cathexis on the intramental "deposit" of his own analysis, and has thus become blinded to any other angles and methods of approach, however expedient in fact they may be in certain cases.—Rev.) The demand for psychological treatment has grown steadily, and the problem of finding better methods of teaching has become urgent.

The authors understand that the mechanical recording of psychiatric and psychoanalytic interviews has been carried out in the U.S.A.; but they have no knowledge of published reports from there. In their research—which was actually planned in 1939—they have been using a magnetic steel wire recording apparatus of the Wirek Electronic Firm, which has the advantage of being able to take an uninterrupted recording for about an hour. It is portable and therefore can be used in hospital, outpatient department, and consulting room.

Medical audiences thought that these records gave a clear picture of what happens in a psychotherapeutic session. Not only the exact reproduction of the content, but also exact impressions of the atmosphere is conveyed. "The method enables one to measure, examine and re-examine;

to compare the different methods of approach; and affords opportunity for the psychiatrist to see and criticize himself.

The method can be used to record the abreaction of a patient's aggression if he is too inhibited to do so in the presence of his physician. In another experiment patients were asked to reproduce before the microphone some of the scenes in which they had lost their temper lately. "The objectivization of these very subjective scenes produced a different attitude in the patient towards the scene." To overcome resistance, one can confront the patient with his own statements by playing back to him selections from former interviews. (The word *selection* ought to be more stressed; it is definitely better if the bulk of previous statements and discussions remains below the threshold of clear memory.—Rev.) "One can, if need be, play back a whole session; this has in several cases released associations. By this method the period of treatment can be shortened."

Intelligent patients were asked to analyze their own records and to note the places where they hesitated or stopped. Patients who were abreacted under sodium amytal were later confronted with the subconscious material produced. The authors say: "So far we have had some puzzling results and we feel that a wide field for research lies in this direction."

A Note on the Treatment of Stammering, Leopold Stein, British Journal of Medical Psychology, 1948, 2, pp. 121-126.

Clinically the initial symptom is the *pure clonus* (Hoepfner and Froeschels). It consists of a prolonged series of rhythmically repeated syllables of words, spoken at the speaker's usual speed. Such patterns are enunciated without apparent physical tension; and the speaker is, at the outset, unaware of the unusual character of his speech. In the *tonoclonus* greater or lesser tension is superimposed on the repetitive utterances; and this symptom is accompanied by uneasiness or even overt fear. The third pattern is called *slow clonus*, and consists of a series of syllables in juxtaposition, separated noticeably by pauses. This form, too, is accompanied by anxiety.

According to Froeschels, the early clonus is based on a disability to clothe ideas in words speedily and adequately enough, as well as on the compensatory "will" to repeat the utterance until the idea can be verbalized. The symptoms of subsequent stages, as well as the tension and anxiety, were likewise attributed to the conscious intention to conceal the fundamental disability. In the opinion of the author, the original, pure clonus is an integral, dynamic sequence of pattern, as for instance: lalalalamp, and not la-la-la-lamp. The latter type is often accompanied by the holding back of breath, and by abdominal pressure concomitant of defecation; or, by the glottal stop which is a typical symbol of anxiety. The *pure clonus*, on the other hand, is produced with ease and without disturbance of respi-

ration. Children with this type of stammer are as a rule as happy as they were before (provided they are not mocked at.—Rev.)

Baby-like babbles possess a "primitive sexual-erotic significance." This is borne out by their high survival value, as can be seen, e.g., in present-day family names in China, such as: *koko*—elder brother, *mejmej*—younger sister, *tshejtshej*—elder sister. *Pater* and *mater*, as well as cognate Indo-European words, are shortened versions of babies' favorite babbles (Weekly 1930). No wonder that such "simple" utterances, possessing a real structural unity, lend themselves to revival as symptomatic acts in disorders of speech, neurotic or organic.

Babbling emerges from the amalgamation of the pleasurable patterns, the rhythmical act of sucking, and the equally primitive and pleasurable grunts, sighs, etc. On phonetic analysis, a babble appears to be divided into distinct "bits," i.e., syllables. Yet evolutionary analysis reveals more archaic, though no less big and indivisible dynamic wholes, one of which is the primarily rhythmical recurrence of sucking noises (clicks). "It may be, thus, permissible to regard babbling as expressive of the primordial pleasurable group-relationship."

When the child is born, that is, separated from the mother's body a new relationship between the two arises. On the part of the baby, the reactions are elicited by two fundamental dangers: that of starvation, which threatens from without, and that of suffocation and overventilation, which threatens from within. The first need is gratified by sucking; the social aspect of this act consists in incorporating the good mother (identification) as well as in the gratification of love, the counterpart of physical hunger. "During the first few weeks, the baby exhibits, on the other hand, strong tendencies towards maintenance of metabolic equilibrium, independence, and self-assertion. In short, it is driven by the urge to be an *individual*. And all this, owing to that other, most primitive anxiety, which is the mental counterpart of the danger arising from the tendency to eject "bad" air in the shortest possible time. The danger of sudden deflation and collapse of the lungs is counteracted by the more or less complete approximation of the vocal cords.

"Two vocal patterns accompany these actions of the cords. One is a rubbing noise produced by the air escaping through the glottis, followed by sound once the vocal cords have drawn sufficiently to close the glottis and allow air to be set in vibration (sighing). If the vocal cords approximate each other gently but swiftly, vocal sound is produced from the start (grunting, crooning).

"Seen from the biological viewpoint, voice appears to be originally a by-product contained in the body's effort to maintain the metabolic (homeostatic) equilibrium (Negus 1920). Vocal patterns, such as sighing, grunting, and humming, in due course come to symbolize such pleasant emotions

as are involved in maintaining the individual's well-being, and thus become expressive of self-assertion and independence; in short, they indicate *me-ness*, individuality, as opposed to *we-ness*, sociality." "The fact that for some months voicing and clicking remain independent from each other seems to signify that the issue of reconciling the emancipation and autonomy . . . with the tendency to become united with the mother is as yet unsettled." Soon, however, the two patterns mingle. The efflux of air, safeguarding *me-ness*, and the influx of air, symbolic of *we-ness*, come to grips, they occur simultaneously. . . . At first there arises a pattern of the type click-voice click-voice (e.g., PaPaPa). This and other patterns develop into *papapa* and similar sequences. The grammarian and phonetician would describe them as rhythmical sequence of syllables. To the child psychologist they are known as babbling. The evolutionist appreciates them as the first specially *human* example of "emergent evolution," in that a new pattern, viz., rhythmical syllables as an integral dynamic unit, has arisen. In it the original components are no longer recognizable to the uninitiated. The consonants contained in it can now be defined as reverse clicks.

"The above-mentioned diverse phonetic functions seem to have been united by reason of one salient quality which they have in common. Both voices and clicks accompany processes safeguarding the individual's psychosomatic balance."

What is, however, most noteworthy in the full-fledged babble is the compromise between vocal sound, as ejection of air and noises produced by rarefaction of air (incorporation). In the pattern such as *papapa* it appears that the tendency to rarefy the air in the mouth is superseded by emission of air, while the erotic mouth gesture involved in clicking remains. This is indicative of the give and take which prevails in the union of the two selves.

"The psychosomatic aspect reveals that the performance of a babble fundamentally and originally has a purely libidinal (erotic) manipulative meaning. Babbles as such *do not* point to objects, until a later stage of development. It is possible that the tonoclonus of the slow clonus has an aggressive meaning, as suggested by Usher. She assumes that the stammerer of the clonic type unconsciously misinterprets the dynamic whole as "bits" in juxtaposition; and, through linking objects with words, this mode of speech suggests "objects in bits" as a result of aggressive tendencies. (Some dreams of stammerers do confirm this interpretation; but the majority of dreams in which the speech disturbance is pictorially expressed do not.—Rev.)

"The unconsciously motivated clonic pattern always remains below the threshold of consciousness." In most cases they fall into oblivion; in some, however, they persist in traces as "a discharge of the respective urge."

"Under the increasing influence of environmental factors, i.e., for the

sake of maintaining unity with the social group by means of the accepted linguistic communication, the babble becomes more or less inhibited. The stammerer certainly shows a tendency towards social cohesiveness. But this lends strength to the inhibition of the pregenital erotic act involved in a clonic stammer. In the long run the reaction to this impulse becomes manifest in more or less rigid immobility, accompanied by anxiety . . . while the original symptomatic act is completely repressed."

The author describes briefly the case of a man with tense stammer who could recall that at the age of four his stammer was that of a baby-like babble. At that time he enjoyed the care and attention his elder sister was giving him. In discussing this matter the patient's stammer became less obvious; the babbling character reappeared particularly in words as *sister*, *serious*, etc. At the end of his account the author adds that the general difficulty in verbalizing thoughts must not be overlooked in the genesis of speech disorders.

It is advisable to let the patient "act out" the pleasurable behavior of early days, and not only the hostilities and anxieties of this period. Moreover, it is necessary to establish the chronological sequence of events associated with the development of the disorder. It is harmful to accuse the patient that he is "unwilling" to give up stammer; because apart from the secondary gains of the morbid condition, the nucleus of stammer is a universal tendency.

"To refer to the *original oral-sadistic* libido is permissible only if such symptoms as are reminiscent of biting the nipple appear to have originated in the initial stage of a given stammer. This, however, is not borne out by analytic findings. Rather do many statistical investigations show that at the inception of a stammer the regression does not lead as far back as Abraham's "Third Stage," that of partial love with incorporation (the Early Anal Stage). Symptoms symbolizing this early level (sucking noises) appear only in a late stage of regression."

ABSTRACTS FROM DUTCH LITERATURE

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ABSTRACTS

Psychopathy and Neurosis, H. C. Rümke, Psychiatrische en Neurologische Bladen, Nr. 5, September-October, 1947, pp. 352-381.

Psychopathy and neurosis are different entities. Psychopathy is a collective name for a great variety of diseases as is, for instance, the word psychosis. We should try to systematize our knowledge of the psychopathies in the same way as we now try to build up a system of the psychoses. The classification into three types of psychoses, (1) disturbances due to

organic brain changes; (2) disturbances due to nature and constitution, and (3) disturbances due to developmental causes—certain psychoses belonging into more than one category—could be used as the basis for a classification of the psychopathies.

Neurosis is the name of a psycho-dynamic symptom complex. Neurosis is a syndrom that may present itself on the basis of different etiological moments. These etiological moments have in common that they lead to a disturbance in the development of the personality. The most fundamental cause for the development of the neurotic syndrom is almost always a deviation, an abnormality of constitution. Therefore, if we compare psychopathy and neurosis, we actually compare one of the psychopathies with a disease that produced the neurotic syndrom. Frequently we may thus compare psychopathy to psychopathy. What has been described as the relationship between psychopathy and neurosis is, consequently, being placed in a quite different light. The similarity between psychopathy and neurosis found experimentally also gains a different importance. This resemblance may be due to the resemblance between psychopathy and a different type of psychopathy and is not necessarily a resemblance between a psychopathic and a neurotic syndrom. It is important to find out whether this resemblance also exists between psychopathy and the very rare type of neurosis which is caused mainly by the influences of the environment. The question whether a neurosis or rather a psychopathy is closer to normality cannot easily be answered. There is, according to Rümke, no general rule about this.

The criterium of curable or incurable cannot be used for a differentiation between psychopathy and neurosis either. There are developmental psychopathies which are cured in the process of maturation. There are a great many neuroses which, due to their basic pathology, cannot be cured.

Closer investigation reveals that the neuro-physiological basis of the neurosis has been unduly neglected while psychogenetic moments have been greatly overrated. The application of the principle of Jackson, that what we observe in the sick, also in the psychologically sick, is normal life under the abnormal condition caused by the negative symptom, would lead us to a much deeper insight into the structure of neurotic symptom pictures.

In the border state between psychosis and normality we find psychic disturbances which may be called "the psychic disturbances of the healthy person." This group, too has never been adequately investigated.

The awareness of the over-emphasis on psychogenesis clarifies the limitations and possibilities of psychotherapy. It certainly does not make psychotherapy superfluous. Psychoanalysis shows us, in an unsurpassed manner, the ways which the neurotic person follows after he has deviated from his normal course of development. In certain cases it is possible

through psychotherapy to lead the deviated person onto normal or more normal roads. This is an important gain even though those symptoms which are rooted in the fundamental disturbance will remain unchanged. The field of the psychic disturbances of the healthy person will always remain important soil for psychotherapy.

Acquired (Post-morbid) Psychopathies, G. Kraus, *Psychiatrische en Neurologische Balden*, No. 5, September/October, 1947, pp. 417-435.

The author starts out with the statement that at present two factors seem essential for the diagnosis of "genuine" psychopathy: (1) The fact that it is innate, and (2) the fact that the disease is constant and non-progressive, yet incurable. For these reasons one might say that post-morbid psychopathy does not exist. The author warns us, that whenever he writes: post-morbid psychopathy, psychopathic changes, states, etc., he actually means: pseudo-psychopathic, symptomatic-psychopathic, or psychopathoid.

Kraus judges that the nosological importance of the acquired psychopathies shows itself most clearly in the variety of etiological moments and he therefore prefers to list these moments, choosing the risk of a "dry enumeration" at the expense of clinical description.

Psychopathic states may result from the *effect of poison* on the central nervous system. In these cases, however, one has to be careful in making the diagnosis of post-morbid psychopathy, as often the psychopathic character traits existed before the poisoning, the intoxication only bringing out those traits more clearly. Especially in cases of chronic poisoning, e.g., through narcotics, the addiction in itself is often a symptom of a psychopathic constitution. It is always the question what and how much is acquired.

Kraus describes the psychopathic effects of alcohol, morphine, cocaine and of long-standing use of sleeping pills, possibly due to lesions of the brain-stem. Certain psychopathic-hysteric reactions during the abstinence training of morphinists seem due to a disturbed balance of the cerebral functions. Külkow described, under the name of "neurasthenia mercurialis" psychopathic states caused by chronic intoxication through mercury. Psychopathic changes have been noticed after poisoning through carbon disulphide; hysteric reactions after poisoning through aniline and benzene. Rawkins and other described character changes at the beginning of chronic lead intoxications with manifestations of asthenia, apathy, shyness, sometimes combined with irritability and withdrawal. They speak of a shift towards the schizoid. It may be of interest (in connection with the importance of the brain-stem) to state that in carbon disulphide and lead poisoning deviations similar to Parkinsonism may present themselves. In

cases of carbon monoxide and manganic poisoning certain authors found personality changes similar to post-encephalitic psychopathy.

Excessive use of iodine may cause psychological changes reminding of morbus Basedowi. Frequent stay in high altitudes may, through lack of oxygen, cause cerebral disturbance leading to irritability, fatigue, sleeplessness, and motor restlessness. Pilots call these states "aero-neurosis." Lack of vitamine, especially thiamine, may cause psychological changes.

As far as internal diseases are concerned, the question of tubercular psychopathy has not as yet been settled. Kraus is inclined to reject a relationship between psychopathy and tuberculosis. However, it cannot be denied that in cases of chronic tuberculosis irritability, lack of control, hypersensitivity, and a tendency to intrigue is frequent. Kraus is doubtful as to whether there is also increased libido sexualis.

In connection with the tubercular process three points have to be reviewed: (1) The affinity of tuberculosis to a leptosome body type may explain why—constitutionally—certain character traits are more outspoken in tuberculosis patients. (2) The awareness of illness, sense of inferiority, fear of death and the influences of sanitarium life lead to emotional disturbances. (3) Certain characteristics may be explained through the effect of the disease on the brain-stem, but there is no proof that resulting psychological or toxic effects are specific for tuberculosis. Kraus is inclined to reject the idea of a specific tubercular psychopathy or of specific relationships between tuberculosis and criminality.

Briefly mentioned are psychopathic states after pleurisy, puerperal infections, after operations, after typhoid abdominalis and sometimes after influenza. Chronic malaria may lead to neurasthenic states and to an explosive emotionality that could be part of a syndrom sometimes described as "tropical neurasthenia." Psychological disturbances after lues (except for lues cerebri and dementia paralytica) are rare. The fact that psychopaths often have lues and thatluetici may be psychopathic does not make a difference. Levie, Ligterink, and Simons described psychopathic reactions in cases of diabetes, regardless of the blood-sugar content.

Diseases of the *organs of inner secretion* may have the character of psychopathic symptoms. Kraus mentions hyperthyroid conditions, myxedema and the disease of Addison. There is no unity of opinion on the psychology of eunuchs and castrates. The emotional changes during menstruation rarely are outspoken enough to be called psychopathic. If they are, then we usually deal with women who had psychopathic tendencies anyway. Pregnancy hardly ever leads to a definite psychopathic character change, in spite of the cases of asocial behavior (cleptomania especially) as described in the literature (Benon). There may, however, be certain changes caused by the influence of the pregnancy on the development of hyperkinetic as well as hypokinetic extrapyramidal disturbances, indicating a change in the function of the pallidostriatum.

There is a manifold connection between schizophrenia and psychopathy. (1) There is, first of all, the problem of the "schizoid psychopath." Kraus is inclined to assume that the schizoid psychopath went through a process of schizophrenia in early childhood. A later outbreak of the disease would be a relapse. Kraus mentions the possibility that the schizoid psychopath may be a post-morbid psychopath. (2) It is a fact that at the onset of schizophrenia psychopathic symptoms are outstanding. One might call these pre-morbid psychopathic personality changes post-morbid in those cases in which the process does not develop any further. This also holds true for most of the organic psychoses. (3) Of importance are the residuals, remaining after a definite schizophrenic process had taken place. It is often difficult to distinguish these post-schizophrenic psychopathic states, without exact knowledge of the anamnesis, from the genuine psychopathies and their true nature is often revealed only through a new outbreak of schizophrenia. Kraus feels that the schizophrenic process as such rather than a possible psychopathic predisposition is the cause of this type of post-morbid psychopathy. The difference can often only be diagnosed by means of the Rorschach test.

Most difficult and often impossible is the differential diagnosis between the flat, shallow, inactive psychopathy and the similar symptom picture following schizophrenia, usually the hebephrenic type. In these cases even the Rorschach test shows very insignificant differences.

Among post-schizophrenic psychopaths may be counted also certain eccentrics and "originals," sectarians and asocial artists as well as the irritable, jealous, suspicious psychopaths, some of them manifesting pseudologia fantastica of sexual abnormalities.

"Psychopathization" takes place in practically all cases of *brain disease*: *lues cerebri*, *dementia paralytica*, *arterio-sclerosis cerebri*, *encephalitis peri-axillaris* and *dementia senilis*. In these cases, however, psychopathic changes do not as a rule persist, but go down into the process of dementia. However, in multiple sclerosis and in cases of brain abscesses and tumors psychopathic symptoms may persist isolated. While psychopathic changes are relatively rare in cases of paralysis agitans, they are predominant in pseudo-sclerosis of Westphal-Strümpell. These changes have also been noticed in patients suffering from Friedreich's ataxia. Peter described a case in which changes in the brain-stem were demonstrated. Very marked are psychopathic symptoms in Huntington's chorea; they are connected with increased emotionality, vagabondage and suicidal tendencies. Psychopathization may be present long before motor symptoms appear. Kraus is inclined to believe that there are cases in "Huntington families" in which at a later age psychopathic changes occur without hyperkinesis ever breaking through. Psychopathic after-effects in chorea minor, rheumatic states, meningitis tuberculosa and in epilepsy need further investigation.

The psychological changes after encephalitis epidemica are often considered as the prototype of post-morbid psychopathies, the discovery of which—according to von Economo—provoked drastic changes in psychiatric thinking.

One must distinguish between the neurasthenic-apathetic changes in adults, also between bradyphrenia in Parkinsonism (changes which, Kraus feels, are not of a psychopathic nature) and the post-encephalitic psychopathy in children and young adults. The post-encephalitic syndrom is a very specific one which has not as yet been clearly differentiated from genuine psychopathy. The difference is perhaps in the intensity and in a partial defectiveness of certain areas of the personality against a relatively well-integrated, normal mental functioning in genuine psychopathy. The post-encephalitic hyper-activity has only a superficial resemblance to the hypomanic psychopathy to which it is often compared. The hyperactivity in the first instance has more a machine-like, compulsive character. Important in the differentiation between post-encephalitic and genuine psychopathy is the intensive "stickiness" and intrusiveness, which are "actually typical for all organic residual states." Kraus considers emotional instability, explosiveness, aggressiveness and especially irritability as predominant traits in post-encephalitic psychopathy. They continue to exist also in akinetic patients behind the mask of Parkinsonism. The mood swings are more marked than in ordinary psychopathy and there is a resemblance to the emotional picture of epileptics. The question as to whether psychopathy in post-encephalitis is purely of an exogenic nature or whether it brings out latent, pre-morbid personality traits has not yet been sufficiently clarified.

Personality changes resembling encephalitis epidemica have been described after measles, scarlet fever, whooping cough, typhus, meningitis epidemica and poliomyelitis. Psychic changes after sunstroke only equal post-morbid psychopathy in serious cases.

As far as traumatic conditions are concerned Kraus attempts to differentiate between neurosis and psychopathy in the following manner: he prefers to consider as neurotic only those symptoms which are caused by the—traumatically conditioned—emotion and the resulting difficulties in adjustment. As post-traumatic psychopathy he considers those changes of character, temperament and instinctual drives which occur—by way of disturbance in the cerebral functions—as the immediate effect of their impact. The author, however, realizes that this still is not a very sharp distinction. Certain cases may arise in which the emotional after-effect of the trauma is so strong as to cause an over-burdening of the cerebral apparatus, thus leading to a disruption of cerebral functions. Kraus warns us that the acquired psychopathy is a pseudo-psychopathy, that the traumatic neurosis is a specific type of neurosis, and that an overlapping between the two

should not lead to general conclusions in regard to the relationship between psychopathy and neurosis.

Post-traumatic changes following injury by mechanic force may resemble the "hyperthymic" and also the depressive forms of psychopathy (cf. Schneider). The picture of affectlessness and moral insanity develop (cf. Plokker, Schaper, Cosack). According to Kraus, mostly in children (cf. Plokker, Schaper, Cosack). According to Kraus, the most outstanding symptom after cerebral trauma is the increased irritability, which is perhaps even more marked here than in cases of encephalitis and is equaled only by the explosiveness of epileptics.

Birth trauma (not in the psychoanalytical sense—*The Reviewer*) is mentioned as a possible cause for psychopathy. Kraus is of the opinion that more children contract lesions of the brain during birth than is generally suspected.

Another type of psychopathy, though relatively rare, is caused by damages to the brain as a result of *brain surgery*. Occasionally there may be changes in character and temperament after frontal lobe excision and leucotomy. Again, one has to be careful as to how much of the psychopathic picture is post-morbid and how much is of a pre-morbid and hereditary nature.

The author refers also to Lange for a description of those cases in which the psychological effect of *physical deformation* or *deafness* may bring about psychopathic reactions. Rümke and de Ranitz have mentioned that excessive need for sweets, due to diabetes, may lead certain children to anti-social behavior. In cases of psychopathic changes following detention in concentration-camps it is hard to discern how much is due to emotional strain and how much is the result of malnutrition.

The great variety of the etiological moments is not equaled by the same variety of reaction patterns. Different causes may lead to a similar pathology. On the whole, the symptomatology is more varied with children than with adults, as in the latter case the personality pattern is already firmly established. While the clinical symptoms do not permit us to form definite conclusions as to the nature of the causes, the question of localization is also unsettled, although there is marked emphasis on the importance of the brain-stem (cf. investigations by Cannon, Foerster, a.o.). Important also seem to be lesions to the cortex and to the cortico-thalamic connections.

The similarities between post-morbid and genuine psychopathy are less important than are the differences. The post-morbid psychopathy is to be considered as a *disease*, while the genuine psychopathy is an *innate deviation of the norm*. In the first case we deal with a disease personality, in the latter with a defected personality. Most of the post-morbid psychopathies do not constitute a stationary situation. Some are progressive, others show a tendency toward improvement. Attention has been drawn

to the fact that the post-morbid states after encephalitis and certain types of trauma in children resemble much more genuine psychopathy than is the case in adults. The following is important: There is a great difference between, for instance, innate idiocy and dementia caused by the destruction of mental faculties in later years. The earlier the brain is affected, the more the picture will resemble congenital, genuine psychopathy. We are often forced to ask ourselves the question whether in cases of so-called genuine psychopathy we do not actually deal with post-morbid psychopathy, acquired in early childhood. Wigert, for one found in cases of so-called constitutional psychopathy a high incidence of encephalographic deviations suggestive of past cerebral disturbances.

LATIN AMERICAN REVIEW

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ABSTRACTS

Psicoanálisis de la Esquizofrenia. (Psychoanalysis of Schizophrenia) E. Pichon-Riviére, *Revista de Psicoanálisis*, Vol. V, No. 2, 1947, 293-304.

This paper was first presented at the First Inter-American Congress of Medicine held in Rio de Janeiro in September of 1946. The author, who has had considerable experience administering both analytic and biological forms of treatment to schizophrenics, postulates a number of general principles concerning psychoanalysis of schizophrenic patients. All psychoses are considered to have their starting point in a basic depressive personality structure and the symptoms appear as mechanisms striving to deal with this primary situation. The psychoses as well as the neuroses are the outcome of a conflict between the id, on the one hand, and the ego at the service of the superego on the other. The structural differences existing between these two types of mental illness are the result of quantitative differences in repression and regression.

The suppression of instinctual drives creates a psychological state characterized by a masochistic ego and a sadistic superego accompanied by a predominately passive-feminine attitude in the male and the reverse in the female thus intensifying the homosexual libido. As part of the process of regression there arises a dissociation of the instincts. Aggression becomes channelled both by the ego and the superego, bringing about the masochistic attitude of the former and the sadistic attitude of the latter. Tension between these two elements of the psyche gives rise to anxiety, guilt feelings, and the need for punishment. Shock therapy satisfies the punishment needs of the patient and thus becomes an effective method of treatment.

The depressive state thus created may be dealt with within the psychological apparatus (melancholic reaction), projected onto an organ (hypochondriacal reaction) or on to the external world (paranoid reaction). Other possible mechanisms result in maniacal, criminal, perverse, and other types of reactions. The only trait specific to schizophrenia would be the regression of the ego to a disintegrated infantile stage with psychomotor phenomena. (The latter is covered at greater length in the author's *Contribución a la teoría psicoanalítica de la esquizofrenia*, Revista de Psicoanálisis, 1946, Vol. IV, No. 6-22.)

Schizophrenia is defined as a mixture of all the mechanisms and reactions enumerated plus the above-mentioned specific occurrence of regression on the part of the ego. The latter results in loss of ego control and the break with reality. The illness always begins on the genital level, and is followed by an object-loss on the primary anal-sadistic level and the recovery of this object on the oral level. This marks the start of the basic depression and the subsequent efforts to deal with it and get rid of it.

The author's theory thus concerns itself with a general explanation of all the psychoses and neuroses taking schizophrenia as his point of departure. He attempts to find a place for shock therapy in the matrix of psychoanalytic theory. He explains the many mixed diagnoses and equivocal cases as well as the passing of the patient from one type of illness to another by his unified theory. His concepts on the etiology and pathogenesis of neurosis and psychosis is a basic departure from the theories of Kraepelin, Bleuler and others who placed emphasis on Classification of mental illnesses and the existence of specific mental disease entities. This makes it possible to consider the use of the same psychotherapeutic methods such as psychoanalysis for all so-called mental illnesses and departs from the idea of specific types of treatment for specific conditions.

Contribución al Conocimiento de la Histeria de Conversion (con Especial Consideración de la Amenorrea Histérica). (A Contribution to the Diagnosis of Conversion Hysteria—with special consideration of hysterical amenorrhea.) E. Eduardo Krapf, Revista de Psicoanálisis, Vol. V, No. 2, 1947, 305-345.

The author presents an intensive study of an interesting case of hysteria with amenorrhoea and attempts to settle the problem of whether and up to what point this menstrual disorder can be understood as a genuine conversion phenomenon. He alludes briefly to the importance of menstrual phenomena in feminine psychology, emphasizing the relative dearth of good psychoanalytic literature on this important subject. He begins by giving a detailed description of his clinical observation of the patient, tracing thoroughly her previous history and the progress of the therapy. Next he examines in detail the family background and intra-familial rela-

tionships, the significance of the genital trauma, and the pregenital structures implied.

On the basis of a skillful analysis of the unconscious material uncovered, Dr. Krapf interprets the patient's amenorrhea as the expression of a wish to "lock herself" genitally in order to avoid, at one and the same time, the genital threat on the part of men, and the still more dreaded menace of punishment by the castrating mother. The dynamics of the patient's recovery was explained primarily on the basis of the fact that the patient found in the analyst the much-needed "good mother." The final discussion of the general psychological meaning of menstruation presents the idea that the woman typically experiences menstruation both as a traumatic event and as a gratifying one, a point of view which the author believes has been disregarded up to the present because of phallogentric prejudice. The author's formulation of this dual significance of menstruation is in harmony with the two-fold genital organization in woman (clitoris and vagina, voluptuousness and maternity, folliculin and progesterone).



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EDITORIAL

The editors of the AMERICAN JOURNAL OF PSYCHOTHERAPY attended a meeting of editorial writers held under the auspices of the American Psychiatric Association, and they came away enlightened and greatly encouraged; for they were convinced that the JOURNAL was in the "right groove", that it was moving in the right direction.

What makes a good journal? A journal is as good as its contributions. The character of a publication is set and maintained by the people who write it, the people who subscribe to it, and the people who read it. Thus the scientific level of a journal is in fact a collective responsibility. It is this collective responsibility we wish to discuss in this editorial.

The foremost task of a medical periodical, as we see it, is to keep its readers informed of the current events and achievements of the profession. The special aim of this JOURNAL is to fulfill this scientific task without resorting to a dry and professorial style. Goethe once said that the Germans have a talent for making science inaccessible. This reference to obscure and involved ways of presenting scientific material is applicable also to some of the articles appearing in our own country. Authors often succeed in discussing the most interesting topics in a most uninteresting way.

We know, of course, that the presentation of psychiatric studies, with their intricate cross-references and their multidimensional structures, requires at all times a considerable literary skill. An added difficulty is that only a small part of the vast quantity of data collected in the analysis of an individual case can be published. Careful judgment must be

exercised in the selection of all that is pertinent and in the omission of all that is expendable. ("Style as Art lives on sacrifice.") How many of us have the power to make the self-emasculating decision to delete, omit, destroy parts of our own manuscripts? And yet, it is on the ability to omit non-essentials that much good writing depends. As Voltaire said: *Le secret d'ennuyer est celui de tout dire*. (The secret of boring lies in telling everything.)

Who are the readers of our Journal? THE AMERICAN JOURNAL OF PSYCHOTHERAPY addresses itself to psychiatrists, psychologists, psychiatric social workers, workers in child guidance, in state institutions, in reformatories, and, above all, to medical students, who are so greatly in need of competent instruction. We are trying to adapt our copy to the needs of our readers, and in doing so we are aware of both the limitations of our specialty and of its close connection with the whole field of medicine including its borderlands.

What type of material is needed? Our readers enjoy clinical presentations, including interesting casuistic observations, and notes on new therapeutic approaches and techniques. Original contributions which provide this information are always welcome. Today, much of the psychotherapeutic literature consists of clichés. We think, however, that the busy practitioner, as well as the busy editor, should be spared the disappointment that comes after the laborious reading of an inconsequential article.

We realize that by urging our authors to abide by the common rules of good medical writing, we assume the role of a tribunal which is itself on trial. However, we believe in sharing responsibilities to gain common objectives. Our candid ambition is to contribute to the advancement of psychotherapy by disseminating progressive psychiatric thought in an interesting and stimulating manner. And we want our JOURNAL to rank high among the fine psychiatric publications of our country.

THEORY AND TECHNIQUE OF PERSONALITY INTEGRATION*

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In the development of man from the lower animal to his present stage, there occurred at least three events of decisive interest especially for the psychotherapist. The first was the development of the cortex specific for the homo sapiens. For the first time an animal acquired faculties different from those which other animals developed in the struggle for survival. The human brain developed the faculty of delaying responses and thus modulating instinctive behavior, and made possible the consulting of previous experiences. This resulted in the development of tools and deliberate action; in other words, at that stage deliberateness supported the spontaneous instinctive behavior in the pursuit of gratification of man's organismic needs and his defenses.

The second stage began when man was required to use his deliberateness not for the support but for the harnessing of instinctive behavior. This occurred at a time when the survival of society assumed more importance than the survival of the individual. However, the instincts were merely harnessed and channelled; there was no tendency to eliminate them as something evil.

The third period began with Greek philosophy, when man became conscious of himself as an object and when he discovered the "mind." Beginning with the Christian notion of the "sin of thought," man, then, turned his will power against himself, forgetting more and more that the organismic needs are the very soil on which he thrives. Dichotomy was born, and it has reached in our time a stage where it defeats its own purpose. The individual in our time lives no more for the benefit of society of which he is a part but for the sake of the production of machines and money. Personal development is, like initiative and many other primary characteristics, projected. The fetish of our time is industrial development, a development in which the workman is more and more required to be an automaton. He produces machine-made parts which, and this is of decisive importance, must show no variation.

* Read before the Association for the Advancement of Psychotherapy, on January 30th, 1948.

In this process, the individual and society are rapidly losing their survival value.

The dichotomy of the human personality can be approached from three angles: From the point of view of the dualistic structure of *personality*, of the dualistic *behavior*, and of the dualistic *language*. Man could regain his survival value if these dualisms could be re-integrated, if he could create a unitary language and a sufficient number of unitary personalities. Individually, we are already capable of doing the latter, but we are far from producing unitary personalities on the conveyor belt. The essential requirement for reintegration would be the production of an adequate tool, and this instrument would have to be the unitary language.

Leonardo da Vinci, Goethe, Freud and Einstein started with the structure of events and kept up the primary contact with the a verbal world, verbalizing only a posteriori what they had found. How different is the approach of most of us! We *begin* with words. We hear "complex," "repression," "libido," "obsession," "schizoid." Then we try to grasp the meanings of those words and go out on our search to find the confirming facts. We shout enthusiastically, "Freud is right! These things *do* exist." Or, if we do not like what we find, we become para-Freudians, accepting bits and pieces here and there and rejecting others. But if we have enough discrimination left and if we do not simply swallow the collected works—those millions of words—we can still hope for progress. However, we must not get stuck in the morass of our own theories. We must not be deceived by the double-tongued, glib, compartmental thinkers who tell us at one moment that the master himself regarded his ideas as mere theories, and at the next moment react with indignation when we have ideas of our own about "libido" and some other treasured labels of their jargon.

Because of the significance of the language problem, it is important that we try to understand it. What makes language so attractive and so concealing? Can one conceive a "means whereby" we can penetrate the linguistic veil that hides reality? Shall we return to our belief in magic or shall we denounce the effectiveness of language altogether? Finally, is our language adequate to the task which we have undertaken; namely, the integration, or rather the re-integration, of human beings?

Our present-day language seems to be a totally inadequate in-

strument for our undertaking. If this is true, how handicapped we are! After all, language is our professional tool, and certainly, any craftsman is seriously handicapped by poor tools. While the surgeon is improving his technique, the atomist building better cyclotrons, the general practitioner using more efficient drugs, the farmer modernizing his implements,—we still try to do the impossible: to integrate personalities with the help of a non-integrative language. A unitary language which would create, or result from, unitary personalities is a condition *sine qua non* for an integrated personal or social structure; but today the development of such a language is in its infancy. (Among others, Korzybski and L. L. White have concerned themselves with the creation of a unitary language.)

At present we are dissociated, dualistic personalities with a dualistic language, a dualistic mentality, a dualistic existence. The deep split in our personality, the conflict between deliberate and spontaneous behavior, is the outstanding characteristic of our time. Our civilization is characterized by technical integration and personality deterioration. The statistics of industrial production and of personality disorder show a parallel increase.

If the assumption is correct that the split personality is the normal, perhaps even unavoidable product of our time, doubt arises as to whether or not an integration is possible, or if so, whether or not it has market value or at least survival value. If an integrated personality, or as I prefer to call it, a unitary person should have a unitary language, how much of an understanding between him and those who use the present-day dualistic language could be achieved?

The examples of Heraclitus, Spinoza, Bach, and Goethe, who were such unitary personalities, are evidence that this is not merely a fantastic goal. On the other hand, Freud, like Beethoven, was a dualistic giant. He produced an apparently balanced scientific system of opposing energies even at the cost of having to introduce his mysterious death instinct, but he did not achieve that degree of unification of his own personality which would have seen dualities as different aspects of the same phenomenon and not as irreconcilable contradictions.

Let us look at some of the prevailing dualisms, for instance the conception of "body and mind." Philosophers tried to glue the

two together in a psycho-physical parallelism. Illnesses are made out to have either psychological or organic causes. In the unitary concept of the organism-as-a-whole, the "body" becomes the visible aspect of the personality while the "mind" appears as a number of functions, especially as attention, which means as a subject/object relationship.

"God and World" is another dualistic concept in the conviction of most believers. The integration which Spinoza accomplished was *pre-mature*; it had no decisive *social* consequences. In contrast, present-day society accepts the integration of time and space, of mass and velocity, as a *timely* expression of our quantitative century, and Einstein's theory of relativity is—at least for the time being—a valid unitary interpretation.

Let us compare Freud's concept of "libido" with that of "attraction." "Libido" as opposed to "aggression" is dualistic; a unification cannot be brought about by integration, but only by behaving like a young dog that tries to bite its own tail. Thus it is not astonishing that we meet in the freudian language monstrosities like "aggressive libido" and "latent negative transference."

"Attraction" belongs to the unitary approach. It is not irreconcilably opposed to "separation"; both expressions mean movement of a body in relation to a field. Thus Karen Horney's ideas about "moving-toward" and "moving-away" types have integrative value. Freud himself saw the antithetical meaning of many root words; e.g., the Latin "*altus*" which we translate with either "high" or "low." He saw the dialectical relationship of a number of processes like sadism and masochism, but in more decisive concepts he retained his dualistic outlook. After he had crystallized, and thereby solidified, his system, it was completed, and no further development can be expected from there.

Alfred Adler was the first to outgrow Freud's system. He saw how one-sidedly Freud had looked at the past and at causes, but he himself was equally prejudiced, over-emphasized the future and purposiveness. Wilhelm Reich refused to accept Freud's vague notions on the means whereby a repression takes place. He found the answer in the muscular tensions co-existent with every neurosis and called the totality of these spasms the motor armor.

The general trend however, seems to go away from the biological foundations of our existence and instead stresses the charactero-

logical aspect and our situation within society (as if a character were put on like the mask in Greek tragedy, and as if we were not society ourselves). Security and adjustment seem to be more important than personality development.

The problem we have to face can now be formulated: How can we achieve the transition from the split into the unified personality, from the dualistic to a unitary language, from the antithetical to a truly comprehensive philosophy?

We should not underestimate either the importance or the difficulty of the task. A progressive dichotomy threatens the survival of mankind. Whether or not mankind is committing suicide or preparing for a more adequate form of existence, nobody can tell at this time. The latter would have to be a re-integrated existence, not an artificially glued-together edifice of incoherent approaches. It entails the acceptance of the organism-as-a-whole with the sincerity of William Alanson White or Kurt Goldstein and not with the lip-service which so many of the present-day movements pay to this concept. Their unitary outlook is blocked by blind spots. They have a piece of the cake and imagine that they have the whole. Their personality is crippled, and their organism-as-a-whole concept corresponds to the specific aspect of themselves which they permit to exist.

The concept of the organism-as-a-whole is the center of the *gestalt*-psychological approach which is superseding the mechanistic association psychology. New York, which as no other place in the world has many different movements attempting to come to grips with psychotherapy, also attracted the three great *gestalt* psychologists, Koehler, Wertheimer and Kurt Goldstein. Goldstein broke with the rigid concept of the reflex arc. According to him, both kinds of nerves, the sensor *and* the motor, stretch from the organism to the environment. The concept that sensing is a passive, mechanistic phenomenon has to be replaced by the insight that we are active and selective in our sensing. I have called the sensory apparatus our means of orientation and the motor one that of manipulation. With this linguistic adjustment, the senses, far from being purely mechanical means for the transport of acoustic and other waves, become once more an aspect of personality itself. Thus the vista is open for an approach in which an individual may again come to his senses.

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We should not underestimate either the importance or the difficulty of the task. A progressive dichotomy threatens the survival of mankind. Whether or not mankind is committing suicide or preparing for a more adequate form of existence, nobody can tell at this time. The latter would have to be a re-integrated existence, not an artificially glued-together edifice of incoherent approaches. It entails the acceptance of the organism-as-a-whole with the sincerity of William Alanson White or Kurt Goldstein and not with the lip-service which so many of the present-day movements pay to this concept. Their unitary outlook is blocked by blind spots. They have a piece of the cake and imagine that they have the whole. Their personality is crippled, and their organism-as-a-whole concept corresponds to the specific aspect of themselves which they permit to exist.

The concept of the organism-as-a-whole is the center of the *gestalt*-psychological approach which is superseding the mechanistic association psychology. New York, which as no other place in the world has many different movements attempting to come to grips with psychotherapy, also attracted the three great *gestalt* psychologists, Koehler, Wertheimer and Kurt Goldstein. Goldstein broke with the rigid concept of the reflex arc. According to him, both kinds of nerves, the sensor and the motor, stretch from the organism to the environment. The concept that sensing is a passive, mechanistic phenomenon has to be replaced by the insight that we are active and selective in our sensing. I have called the sensory apparatus our means of orientation and the motor one that of manipulation. With this linguistic adjustment, the senses, far from being purely mechanical means for the transport of acoustic and other waves, become once more an aspect of personality itself. Thus the vista is open for an approach in which an individual may again come to his senses.

Now we meet on familiar ground. The senses are the means of awareness, consciousness, attention. Lack of awareness is characteristic for the neurotic. Insufficient awareness of past traumatic experiences has been considered by Freud as the cause of the neurosis. Frigidity and scotoma are two more examples of diminished awareness. I have studied extensively the corresponding phenomena of the alimentary tract.

Quite briefly, my theory is the following: Difficult situations create wishful and magic thinking, scientific manipulation, propaganda, and the philosophy of the free will; in short, deliberateness in place of spontaneity. Human behavior, as far as it was and is objectionable to a person or a group, has to be changed, but the "goody-goody" behavior is not replacing, it is only superseding the spontaneous attitude. Instincts as the source of unwanted behavior cannot be eliminated, only their expressions can be modified or annihilated. Generally, it is the expression and execution of the organismic needs, of the biological, original personality which is scotomized and paralyzed. Consequently, the modern individual has to be re-sensitized and re-mobilized in order to achieve integration.

If we set out with the idea of correlating the sensory-motor nervous system to orientation and manipulation, we arrive at an unbroken chain of interdependencies which begins with the rapid automatic reaction, the so-called reflex, and progresses to the delayed responses of medium and high order. A convenient example of the medium order response is rifle shooting. A perfect and continuous co-ordination of orientation and manipulation, a permanent adjustment to the changing situation, is required to hit a moving target. The property of the human brain to delay action is already pronounced in this example. Climbing up the ladder of abstractions, we come to the high-order activities of planning, blue-printing, theorizing, and finally, to philosophizing. Every theory, every philosophy is a map from which we take our orientation for our actions. An adequate map is one that represents reality as truthfully as possible at any particular time. However, if one opens an atlas one finds all kinds of maps; some give an orientation about the geography of a country, others tell about the political or ethnographic situation. In addition, one can get information about wind movements, data on economics, or whatever aspect of reality one is interested in.

In other words, reality *per se* does not exist for the human being. It is something different for each individual, for each group, for each culture. Reality is determined by the individual's specific interests and needs.

Everything is in flux. Only after we have been stunned by the infinite diversity of processes constituting the universe can we understand the importance of the organizing principle that creates order from chaos; namely, the figure-background formation. Whatever is the organism's foremost need makes reality appear as it does. It makes such objects stand out as figures which correspond to diverse needs. It evokes our interest, attention, cathexis or whatever you choose to call it.

Bring the Sunday's *Herald Tribune* into a large family and watch the diversity of interests. Father seeks orientation in the business section, while mother skims the paper for basement bargains. Alec looks for instances of hardships of the suppressed classes, while Jack gets enthusiastic about a football game. Aunt Jenny indulges in the obituary columns, and the twins fight over the funnies.

The most important fact about the figure-background formation is that if a need is genuinely satisfied, the situation changes. The reality becomes a different one from what it was as long as the situation was unfinished. A neurosis is always characterized by the great number of unfinished situations. The patient is either not aware of them or is incapable of coping with them, which means that he is limited in his orientation or his manipulation or in both.

The healthy organism rallies with all its potentialities to the gratification of the foreground needs. Immediately as one task is finished it recedes into the background and allows the one which in the meantime has become the most important to come to the foreground. This is the principle of organismic self-regulation. Wilhelm Reich has dealt with this principle in connection with the orgasm and has contrasted it with the principle of moralistic regulation. I would prefer to call it the principle of deliberate regulation.

The psychotherapist's philosophy determines his specific approach. The priest will purify the soul with methods that increase the awareness of the sinfulness of the forbidden deeds; the medicine man will attempt to change behavior by the use of bromides; the witch doctor will apply magic. The Freudian is concerned

with the extraction of childhood traumata; the Adlerian with pumping confidence into his arrogant (inferiority-stricken) patient. If a school regards the inconsistencies of character as the root of all evil, it will endeavor to reconcile them; if the self-system is at fault, its stabilization will bring security into the interpersonal relations. If the perfect sexual orgasm produces the perfect personality, the therapeutic effort will be concentrated in that direction; and if incomplete awareness and immobility, as I suggest, are the scapegoats of the personality disorder, the method in question will be the re-sensitizing of the figure-background awareness and the re-mobilizing of all potentialities of the personality. This includes the harmonizing of both deliberate and spontaneous attitudes.

The ultimate goal of the treatment can be formulated thus: We have to achieve that amount of integration which facilitates its own development. This is in accordance with the fact that the dissociated person is inhibited or even degenerating in his development. To repeat once more, the criterion of a successful treatment is: the achievement of that amount of integration which facilitates its own development. A small hole cut into an accumulation of snow sometimes suffices to drain off the water. Once the draining has begun, the trickle broadens its bed by itself; it facilitates its own development. This facilitation of its own development should be given an important place in child education. The child requires, firstly, the gratification of its immediate needs and, secondly, the facilitation of its development.

But the child is, even with well-meaning parents, seldom given the facilitation of development of its inherent potentialities. It has to be shaped into something that finds the approval of parents and society. This entails two kinds of processes: the crippling of *some* attitudes and an artificial development of others. The spontaneous personality is being superseded by a deliberate one. On the behavior level we see the same dualism at work as we discussed previously in regard to the linguistic level. Spontaneity and deliberateness fight each other, producing conflicts, inconsistencies, distortions, discomfort in our civilization, while the integration of spontaneity and deliberateness could produce men capable of self-expression and self-realization.

Volition, conscience, living up to expectations, or whatever one chooses to call these deliberate attitudes, does not necessarily mean

an inconsistency within the personality or a conflict with the environment, but it will lead to dichotomies if it is in conflict with the deeper layers of the personality, if it leads to the production and accumulation of unfinished situations within the personality. The unfinished situations cry for solutions, but if they are barred from awareness, neurotic symptoms and neurotic character formation will be the result.

Man is part of nature, he is a biological event; therefore, society is also part of nature. Speaking is a time-space event; so is thinking. Every abstract notion is as much a process as is the visualization of an object. Deliberate activity, self-control, conscience, are *social* and at the same time *biological* functions. Re-integration can be successful only if every human activity, deliberate as well as spontaneous, thoughts as well as instincts, are regarded and treated as biological processes.

Even at the risk of being redundant, this theme merits elaboration. A symptom is like a book, a precipitation of processes. The processes of observing, verbalizing, writing, selling, printing; the processes of making paper, ink, compositor's metal; the processes of distributing, advertising, and many more make up a book. Once it has become form it can partake in a variety of further processes. It can become a weapon to be thrown at one; an object to barter for a bit of food; something with which to show off, or something to hide from parents; something to be burned by the Nazis; it can even become something to be read. In the latter case, the receptive processes are considerable and vary from staring at it to introduction, and even to digestion and assimilation.

Likewise, a neurotic symptom is the precipitation of processes; a hysterical headache, for instance, may be the end-result of being touchy, wanting to cry, being heroic about it, then squeezing the eye muscles until they hurt. Such a symptom can be used to get sympathy, an aspirin, or a thorough neurological examination. It can also be analyzed and its contributing processes integrated.

Functional and evolutionary experimentation are the characteristics of global organic life. The baby is experimenting with sounds; the kitten with the strength of the branches it wants to climb. The schoolboy experiments with the teacher—how to cheat him or how to be in his good books. Once he has developed attitudes which appear to function adequately, he proceeds to other experiments.

The neurotic is always characterized by inadequate functions, mostly in the direction of unnecessary activity. This is most obvious in the obsessional type, but all neurotic character features are of a compulsive, rigid nature in contrast to the healthy experimental elastic attitude. The malfunctions of the neurotic become manifest in his lack of genuine self-expression. He can not reveal himself before himself, and still less before others. His interpersonal relations as well as his development will, consequently, more and more deteriorate.

What technique is at present available to integrate the personalities of our patients; that is, to restore the organismic balance and to open the way for productive self-realization?

Freud's experiments with hysteria made him finally reject the hypnotic technique and develop a procedure which is now rigidly followed by the classical school. His pioneering spirit is found in the unorthodox rather than in the orthodox movement. Nature is experimenting lavishly; many of the species and individuals it produces show no survival value. In the same way, many of our attempts to find a solution will be abortive; but a *movement* which is petrified is an absurdity, a contradiction in itself. As long as it does not cope with changing situations and does not assimilate whatever valuable knowledge is available outside the temple, it will cease to remain a factor in the development of mankind. The psychotherapist who is scotomized with regard to semantics and *gestalt*-psychology, to mention only two tools developed since Freud, will soon be out of date.

At present, my technique is based on function and experiment. What I will do next year, I cannot tell. Our aim is integration, and the analytical procedure is only one of many instruments towards this goal. I try to find out as much as possible about the patient's personality disorder by observation and discussion. Some dissociation or other is bound to become manifest in the first interview. Some anxiety, some talking around the subject will provide the opportunity to show him the existence of unrealized conflicts.

These conflicts have one pattern only: the identification/alienation pattern. This means: the patient identifies himself with many of his ideas, emotions and actions, but he says violently "No!" to others. Integration requires identification with all vital functions. Every attempt at integrating is bound to bring to the foreground

some kind of resistance, and it is this bit of resistance I am after and not the content of the "unconscious." Every bit of *re*-sistance that is changed into personality *as*-sistance is a double gain as it sets free the jailer and the jailed.

I am fully aware that the patient cannot be immediately successful in the tasks which I put before him. If he could, he would not need my assistance. In this connection let us investigate the basic freudian experiment: the demand that the patient should say whatever is in his "mind." Actually no patient is free in his self-expression. In an attempt to comply, he often gets the feeling that resistances are something bad, something that he should not have. He develops a technique of apparent compliance but keeps his statements on a dead verbal level. He talks *around* his resistances instead of *about* them; the barriers—embarrassment, fear, and disgust—which produce the dissociation are not experienced. The analysis is often kept on a level of unreality, for everything is related to a transference, that means to something that actually does not matter. The contact with the analyst is a blank; in it, interpersonal relations cannot be examined and discussed. Free associations, originally meant to clarify the meaning of a symptom, degenerate into a flight of ideas.

I can see no other way out of this dilemma than to start with the obvious, with the situation in which the patient finds himself during the interview. I suggest, for example, the following experiment: Let him begin every sentence with the words "here and now" and observe how he reacts to it. He may be co-operative or he may be a "slick customer" and begin a few sentences with "here and now" and then slip into yesterday and tomorrow at the first suitable occasion. Or he may be one of the obsessional types who attempt to make fools of other people. He might ridicule the experiment by saying, "Here and now on Friday I visited my friend." Another might ask, "What has *this* to do with *my* problems?" You can already appreciate from these few examples that the attitude of the patient is, as everywhere, also coming out in the session. Thus, if his character changes in his relation to the analyst it might also change in his other relationships. Already the first reactions give the analyst and the patient an opportunity to discuss some basic attitudes, the tendency to escape from the present, that is, from contact with reality, or the tendency to fool one-

self and others (this is mostly not conscious) or the knack for plausible rationalizations.

Sentences like "Here and now" or "Now I am aware of" are chosen not only to bring out the top layer of the patient's character formation and some of the more primitive resistances but also to clear the path to the recognition of all his functions, especially, his disfunctions, conflicts, attitudes of escape.

I have previously discussed the relativity of reality and its determination through the figure-background formation. When I use as synonyms, reality and actuality; when I stress the importance of "Here and now", I expect the Freudian to ask: "What about the past and the causes of the neuroses?" and the Adlerian to protest: "What about the future and the aims of our existence?" To these I must say: Unitary thinking does not recognize past, present, or future; it only recognizes processes to which we can artificially ascribe a beginning. If we like, we can call the beginning cause and the future event purpose. Unitary thinking recognizes, however, *recordings* of previous events and forms as precipitations of previous functions. It recognizes as aspects of the so-called future: planning, hope, predictability and vectors—but it maintains that these processes take place here and now. Moreover, a single sentence, even a word, is a time-space event. When reading a complex sentence, one may, as might be said, return to the past in order to pick up the lost thread, or as I would formulate it, consult quickly one's acoustic recordings to produce a meaningful *gestalt*.

Existence is actuality. It is awareness. For Freud, the present included the past 48 or so hours. For me, the present includes a childhood experience if it is vividly remembered; it includes a noise on the street, an itch on my cheek, the concepts of Freud and poems of Rilke, and millions of more experiences whenever and to whatever degree they spring into existence, into *my* existence.

The initial difficulties in putting across the concept of functional thinking are sometimes considerable. Perhaps one can generalize and say: The toughest resistance is provided by what to the patient appears as obvious. To him it is obvious that one does not insult the analyst. It is obvious that one produces memories and, if possible, childhood memories. It is obvious that resistances are something undesirable, that one should not have them. It is obvious that one's difficulties have causes; that talking will bring the solution; that the therapist is either God or a fool.

Peculiarly enough, all great progress was made by examining the obvious. After taking over unsuccessful cases from other therapists, I have frequently discovered that the obvious had been taken for granted, not only by the patient, but by the therapist as well.

Here are several examples.

Case 1: A man had had sixteen months of analysis. He liked his analyst and the analysis, but he had the impression that he had not made much progress. The obvious consisted in his case in the fact that analysis meant for him lying on a couch and telling to the analyst all the unpleasant experiences of the previous few days. This obvious attitude was his means of preserving the status quo; namely, to bring up whatever he could not stomach. Instead of tackling any of the unpleasant experiences and profiting from them, he just "swallowed" them and "vomited" them out in his analytical sessions. He was not aware that he gulped down all his physical and mental food, but he was very much aware of a troubled stomach. He was not aware that he did not assimilate his experiences, but he knew that he had difficulty in understanding the world.

Case 2: A lady who had considerable experience with psychotherapists put herself on the couch, lay stiff as a corpse, talked like an automaton and produced associations entirely irrelevant to her present life. She was dismayed to realize that I was not interested in the material she produced but only in how she produced it. Her previous analyst had not even noticed the obvious; namely, that this playing the corpse, this desensitization and the immobilization was the center of her armor, of her resistance. The personality behind this armor showed a degree of disintegration approaching the psychotic border. I do not hesitate to make the classical technique responsible for this state of affairs. After six months of treatment she showed good recovery and a noticeable degree of integration.

Case 3: A girl's obvious behavior was characterized by her continuous complaining about this or that person. She was full of complaints about her previous analyst. On my asking her what *he* had had to say about these complaints, she answered that they were never discussed! And this happened with an analyst who believes in the transference mechanism! After having shown her that the complaining about someone to somebody else—for instance, about me to a friend—instead of to his face was her way of avoiding aggressive contact, we proceeded to experimenting with her attacking me. In this process a good deal of the previously unrealized fear and embarrassment came into the foreground.

Case 4: A sculptor had derived satisfactory benefit from treatment by a progressive analyst; finally, it was decided to change analysts because two important symptoms stubbornly remained: his inability to work and

his obsessional thought of killing his wife. After one of the first interviews I suggested that he should experiment with sculpturing the killing of his wife. The next day he returned enthusiastically, informing me that for the first time in years he had worked for three hours with interest and pleasure. His ability to express himself with pencil and clay, that is, on the a verbal level, continued to be a great help in his treatment. The obvious that was overlooked in his case was that modeling, not language, was his means of expression.

In contrast to these cases there are those with whom I can achieve only little or no satisfactory integration. Apparently, they take their customary outlook so much for granted that no other orientation seems feasible to them. In these cases I either lack the ability to show them convincingly the need for change and re-orientation, or else I myself am insufficiently integrated to be aware of the crucial resistance.

A psychologist was sent to me because she showed a number of characterological symptoms; among them was the desire to become a psychoanalyst. In spite of occasional emotional outbursts there was no possibility of breaking through an armor of confused verbosity, a state which Landauer so beautifully called *faselige Verbloedung*. She refused to accept her need for personal treatment. We finally parted after she had decided that she could not afford a therapeutic analysis although she was willing to invest money to obtain the "easy and glamorous" life of a psychoanalyst.

At present, there are two more cases with me which look very doubtful. One is a paranoid man, the other is a near-schizoid young woman. The first's slogan for life is: "Rather to be important than healthy." The other's: "Rather to be clever and crazy than healthy and stupid." In both of these cases I have not been able to obtain satisfactory co-operation. Whatever experiment I suggest to the former, he proves to me that he can do it and leaves it at that. He behaves like a soldier who goes to war, shows his officer that he is able to hit the target and then thinks that he can go home. For him the war is over.¹ What characterizes both cases more than anything else is their crippled spontaneity. Scheming and deliberate acting, blue-printing and preparing for all eventualities, in short, the futuristic thinking has become the obvious approach to life; thus contact with actuality has lost all meaning. Both are most of the time *beside* themselves and not *within* themselves. They are not "all there", in the true sense of the phrase.

¹ Since the time this paper was written, his prognosis has improved.

Once one has worked through the basic character resistance, the battle is won. Not that the patient can achieve awareness entirely on his own, but from that point on the increasing integration reverses the vicious circle of the neurosis. More and more, the "I" against "you" turns into a "we." Especially the second phase, the recognition of the motor tensions, of Reich's muscular armor, may evoke the patient's interest. Many a neurotic is given to hypochondriasis and other forms of introspection, and this phase of the treatment gives him plenty of opportunity for self-observation and, at the same time, a technique to cope with certain gross symptoms such as headache, backache, or anxiety states. Even should he apply the basically "wrong" method, that of relaxation, he experiences what appears to him miraculous results.

A lady continued with me after her former analyst had discontinued treatment because of her negativistic and aggressive attitude. She had originally started the analysis because of high blood pressure, a chronic pseudo-asthma, frigidity, and family difficulties. So great were her breathing difficulties when she started with me that she could scarcely speak. First, I decided to tackle her asthma and postpone work on the deeper personality disorder. After a few hours of reorganizing her breathing, she burst into tears of deepest despair, and with this she obtained her first relief. Three months later her asthma and high blood pressure had disappeared, and now after six months she has lost her frigidity. At present we are working on her self-consciousness. One experiment in particular brought home to her the mechanism of her armor. At a distance of about ten feet from me she was relatively at ease; upon coming nearer, she stiffened more and more and again lost the tenseness with distance. This reaction worked in an entirely automatic way. It was necessary to make her realize that *visualizing* the approach of somebody produced the same effect, and further, that she was not only stiffened but that she was also stifling something.

Besides Reich, there are a number of other schools that tackle the organism from the physiological functional aspect, or to speak in dualistic language, which do body-analysis. They are, like the purely psychologically-minded, condemned to the Sisyphus work of the never-ending unfinished situation. They have it, and they have it not. A certain amount of integration is possible; they are justified in their work because it is correct, but they do not realize the onesidedness, the incompleteness, and therefore, the non-integrative nature of their work. Of course, they all claim, like many

psychologically- or semantically-minded, that they deal with the organism-as-a-whole. All these movements, like the schools of F. M. Alexander, Elsa Gindler, and Jacobson of "you-must-relax" fame, will assist any kind of good psychotherapy. The greatest danger here is the same as with compartmental thinking and as with every non-comprehensive approach; namely, the avoidance of the crucial issue and the concentration on a dummy.

The person who shuns the solution of his sexual difficulties will often avoid the classical school. An analyst who unconsciously wants to exercise his lust for power will be careful not to assimilate the teachings of Adler or the Washington school. The man who does not want to face his inner conflicts will be attracted to one of the body-analytical schools. Thus, only a therapist with a comprehensive view will be in the position to spot and to tackle the central difficulties which the neurotic avoids facing.

Typical of the incomprehensive attitudes is the fetish of relaxation. Of course, a patient can go a long way in learning to relax, but he will become tense again in every situation where relaxation is not a figure, where he is confronted with some unwanted sensation, action, or emotion. It is not easy for our patients to learn that they are not required to relax deliberately but rather to become aware of the inner conflict of which the tension is only a part.

This brings us to the next step in integration. (As always, this subdivision into steps is artificial, and the different stages frequently overlap.) In this period the patient should get thoroughly acquainted with the structure of his inner and outer conflicts and the acceptance/rejection concept. In the previous period he should have learned that a permanent stream of consciousness is going on, except in sleep or trance. He has become acquainted with a multitude of processes in the outer and inner world. In the present period we examine these processes in detail. Which ones are spontaneous? Which ones has he invented in order to comply with the analyst's expectation or his idea of treatment? Is his attention erratic or does he give the processes a chance to develop and become complete? How does he avoid following up the processes? Is he escaping into intellectualization, into facetiousness, into the past or the future, into listening to outside noises, sleepiness, monotonous speech, etc? He is already aware of a certain amount of censoring and realizes primitive conflicts such as "This is embarrassing to tell", or "I should not think such things", "I

want to relax, but can't'', etc. The main difficulty lies in the fact that he mostly identifies himself with the censor. To him it is obvious that one should not criticize one's doctor, that people should have a good opinion of him, that it is permitted to hurt oneself but not others. However, by working through his muscular tensions, he is becoming much more aware of the structure of many conflicts; for instance, his efforts to suppress crying, anger, and so on.

The patient soon learns that the censoring is done by a very simple principle, by accepting and rejecting. He also learns by experiment to accept more of his drives and wishes. He realizes that by accepting and expressing his emotions he can get cathartic relief, and finally, that his ideas of accepting and rejecting are largely correlated to his pattern of orientation; namely, to his need for being accepted and his fear of being rejected by the world. He is astonished that in spite of his great need for approval, neither praise nor other tokens of acceptance have lasting effect but that *refusals* can worry and hurt for a long time. This apparent inconsistency results from the characteristic neurotic tendency to leave many situations unfinished. If he learns to listen to the figure-background language of the organism and to act according to this reliable means of orientation; that is, to complete the unfinished situation, then he will be able to restore the balance of his personality and pave the way for productive development.

Let us take two simple examples of unfinished situations: one has the urge to urinate or one has an important letter to answer. One can reject the urge for a considerable time but the conflict between retaining and letting go will cost more energy than finishing the situation which would not take more than a few minutes. The same applies to the letter. The answer can lie on your conscience for days and weeks while the actual writing may cost you no more than an hour. Rarely will the situation finish itself merely by the passage of time and then usually not to your advantage.

Sleeplessness is a frequent symptom of unfinished situation; so are dreams. Probably the most important part of the dream is its end. Often the dream works towards the solution of a problem, but the dreamer cannot even stand the awareness during sleep and prefers to wake rather than finish the dream. Therefore, he wakes up before his wife gets smashed on the pavement since in the dream she has fallen out of the window, or before he enters the vagina in a love-making dream.

The next phase could be called *topological* re-orientation and reorganization of language.

Topological orientation is concerned with three processes, introjection, projection, and retrojection. In this paper these very interesting concepts can be treated only superficially. Each really requires several chapters. All three phenomena are symptoms of a lack of integration. In reference to introjection I disagree with Freud who recognized it as a pathological phenomenon only in total introjection and considered partial introjection to be a healthy process providing the building stones of the ego. My own contention is that every introject, be it partial or total, is a foreign body within the organism. Only complete destruction as preparation for assimilation will contribute to the maintenance and development of the organism. De-struction does not mean annihilating but rather the breaking down of the structure of physical or mental food. Freud said that it is not enough to bring material into consciousness, it must also be worked through. According to my analysis of the alimentary functions, I formulate this insight in this way: It is not enough to bring up undigested material; it also has to be re-chewed so that the digestive process can be completed. This was true of the patient described earlier who annihilated the events he could not stomach by bringing them up in the consulting room. The cure involved resensitizing of the dead palate, becoming aware of the disgust barrier, remobilizing the clenched jaw, and investing his aggression in biting and chewing.

The topological aspect in regard to projection is obvious, but it requires special scrutiny. How is it that some part of a personality which should be experienced as belonging to the personal structure is disowned and treated as belonging to the outside world?

The child lives in confluence with its environment. It has not yet developed its contact functions, this means, it can not differentiate between self-ness and other-ness, between subject and object, between projection and self-expression.

Confluence means the non-existence or non-awareness of boundaries; means taking one-ness for granted. Confluence in the adult is sado-masochistic fixation, disguised as love. Hatred is frustrated greed for confluence; contact is appreciation of differences. Boundary means contact *and* separation: it means individuality.

If the state of confluence does not develop into the ability to make contact, or if by later de-sensitization the boundary is

breached, then the infantile projection mechanism remains. Self-expression does not develop, as it presupposes the recognition *and* manipulation of the boundary. With this lack of adequate self-expression, an emotion will not be expressed and disposed of by emotional discharge, but it will be projected and remain in emotional connection with the personality. The personality becomes depleted and the projected properties cease to be useful instruments in the pursuit of personal aims. The paranoiac remains connected with his persecutor through hate, the religious person with his God through awe. Whether aggression, initiative, or responsibility is projected, in each case the result will be a crippled personality. Many neurotics project tendencies to accept and reject and thus cannot integrate these functions into discrimination. They remain connected with these projected tendencies by greed and fear.

The projection mechanism is connected with the linguistic problem. Through the projection of initiative and responsibility our patients experience themselves in a permanently passive role. A dream occurs to them. They are *struck* by a thought. Speculations go through their minds, brains, or whatever vacuum they choose for their perambulation. More specifically, this refers to the patient who is not willing to identify himself with his activities, who talks about his hard luck, about fate; who is the victim of circumstances. If his language is reorganized from an "it" language to an "I" language, considerable integration can be achieved with this single adjustment. One has to start this linguistic adjustment during the work on the muscular armor. Not before the patient fully realizes that there are not spasms in the small of his back, but that *he* is contracting, stifling feelings with the help of certain groups of muscles, can he develop or regain his ego functions and make contact with his muscular activity. Only then can he release tensions deliberately, for conscious control is indispensable for experimenting with whatever amount of rejected emotions or sensations he can tolerate and integrate.

The unity of linguistic and structural reorganization is equally essential in the treatment of retroflexion. Retroflexion is, one might say, the daily bread of the psychoanalyst. It coincides approximately with what Freud called "secondary narcissism." My objections against accepting this term are several. First, the so-called primary narcissism is not a pathological state. On the con-

trary, the lack of it, the lack of self-awareness, is detrimental to the personality. Second, retroflection or secondary narcissism has taken on a significance far beyond self-love, while in the customary language a narcissist remains a person in love with himself. Third, a descriptive term like "retroflection" is preferable to a purely symbolic one.

Retroflection is characterized by the word "self." Self-love, self-control, self-punishment, self-destruction, self-consciousness, and so on.

In retroflection one part of the personality is split from the other but it remains in active connection. Object relationship is replaced by an "I and Self" relation. In active retroflection, a tendency, e.g., love, destruction, control, scrutiny, etc. is directed toward one's own person. On the other hand, in passive retroflection, the "I" replaces the missing active object; I pity myself because nobody else does it; I punish myself in anticipation of someone else doing it to me.

Once the patient understands this mechanism he is on his way to recovery. Instead of being in a clinch, both parts turn toward the world; contact and expression are facilitated. *Self-reproach* will lead to depression and important resolutions, while *object reproach* leads to object approach, to having it out, possibly to finishing a resentment situation.

In the projection mechanism, desensitization is apparent; in retroflection the mal-functioning of the motor system is more obvious. As a matter of fact, the good response to treatment is a result of the fact that the retroflective process can be easily demonstrated. Whether the origin of the muscular suppression is the training in cleanliness or, as is more often the case, the hanging-on-bite, is immaterial. What is important is that a tremendous amount of motor energy is invested in the inhibition of catharsis and initiative. The muscular mal-coordination is precipitated into symptoms which then constitute the manifest problem; clumsiness, constipation, asthma, headaches, etc.

Finally, we have to mention another set of powerful processes, the emotions. Just as the visible manifestations of processes in the human organism received the name "body", just as the awareness of the orientation/manipulation functions were called "mind", so the totality of the emotions was called "soul." This term tends to disappear in correlation to the progressive degeneration of our

culture cycle in general and to the progressive emotional depletion of the neurotic individual in particular.

This depletion leaves the individual and society with ever greater unsureness, with the need to replace the biological means of orientation by intellectual ideas, by moralism, and by perfectionism. The pleasure-pain principle represents the biological compass whereby the organism finds its bearings, away from the painful and toward the pleasurable situation. Admittedly, a primitive compass, but one which is absolutely necessary for the individual's survival. What is good and bad for the individual coincides less and less with what society determines as good and bad, and still less with the neurotic's moralistic notions.

Integration, in the final analysis, is prevented by the desensitization of the emotional barriers, especially the disgust, embarrassment, shame, anxiety and fear barriers. Indifference is the best way of avoiding these experiences. Once these barriers come into existence, the patient still will avoid the complete situation, namely the conflict between self-realization and the interfering emotions. The negative emotions are indeed essential for the dichotomy of the personality. We have not only the task to expose them, but we also have to turn them into co-operative energies. During this process we encounter a transitory phase. Disgust turns via greed into discrimination; anxiety via excitement into specific interest, such as hostility, sexual excitement, enthusiasm, initiative, etc; fear via suspicion into experimentation, that is, into widening the orbits of one's life; and embarrassment via exhibitionism into self-expression.

The treatment is finished when the patient has achieved the basic requirements: change in outlook, a technique of adequate self-expression and assimilation, and the ability to extend awareness to the a verbal level. He has then reached that state of integration which facilitates its own development, and he can now be safely left to himself.

The changes which he experiences compare with his previous state in that he is now *actually* growing up while previously he tried to realize his infantile concept of an adult. Instead of taking his orientation from his desire to be accepted and his fear of being rejected, he is now doing the accepting and rejecting himself. Instead of living in oscillation between a jelly-like confluence with, and complete isolation from, his environment, he knows now that

"contact" means acknowledgement of differences. Instead of experiencing himself as an outcast, he recognizes that he is a cell in the larger social organism, and that to be effective in this organism he must function to the best of his ability. He will integrate his interpersonal relations not by servile adjustment and sacrifice of his self-realization but by selecting contacts that make for a rich productive existence.

Most of us realize that the science of personology is in its infancy and that much work has still to be done. The period of classical analysis is drawing to a close. In a few decades it will have a mere historical interest. The present period, which could be called "the para-freudian interval," started with the dissension of Alfred Adler. It is characterised by a multitude of promising re-orientations, but also by a peculiar unsureness manifesting itself in a high degree of intolerance toward schools of different orientation. There must be a way to overcome this sterile isolation and mutual intolerance. There is a tie that can unite all of us: the frank acknowledgement that we know very little, that our orientation is as crude as the maps of the Phoenicians, that compared with other branches of knowledge we are *beginners* like Hippocrates or Paracelsus.

Have you ever been in despair when one of your patients had his vision blocked by his or your pre-conceived ideas, and didn't you wish then—to quote Freud—that he should display a more benevolent skepticism? I shall be very happy indeed, if my paper has encouraged you to be benevolently sceptical towards both your own and my present convictions and to make the transition from any compulsive dogmatism to the experimental, insecure, but creative, pioneering attitude for which I can find no better example than the courage of Sigmund Freud.

A CASE OF EXHIBITIONISM WITH SPECIAL REFERENCE TO THE FAMILY SETTING

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GENERAL REMARKS

Exhibitionism was widespread among primitive peoples. The phylogenetic residuals of this phenomenon are to be found in most children of pre-puberty age. Among adult groups we find vicarious expressions of exhibitionism, as for instance, in nudist cults.

But there is a form of exhibitionism that is regarded by some as pathological, by others an anti-social act punishable by law. Whatever the attitude towards this phenomenon, it represents a socio-psychological challenge that can be met only with a continued scientific investigation of its psychopathology.

The justification for submitting the following case for publication lies in the fact that there are a number of unusual features that make the case rather unique. Of importance also is the fact that a satisfactory therapeutic result was obtained following a fractional analysis of the patient, an analysis which was handicapped by insufficient anamnestic material.

The family history was heavily tainted. Both parents are highly neurotic; the father, a professional teacher of religion, once attempted suicide because of an acute conflict between religion and sex; the patient's parents frequently exposed themselves before their children at home. The mother, for instance, thought nothing of taking a shower while her son (the patient) was brushing his teeth in the same bathroom. A maternal uncle was reported to have been in a mental institution, while another was discharged from his position as school master because he had exposed himself before his pupils. The hereditary factors as well as the highly sadistic nature of the patient's fantasies make the case an interesting one from the standpoint of psychosexual pathology.

INTRODUCTION

The patient is a 19-year-old boy who exposed himself for the first time at the age of fourteen. In the past five years he has exhibited himself before persons of the opposite sex in public parks,

street cars, busses, approximately a dozen times, and has been arrested on three separate occasions. He was released the last time under the condition that his family would place him under the supervision and treatment of a psychiatrist.

His analysis began in 1943 and extended with many interruptions over a period of a year. At the beginning of the treatment he was living at home with his parents, employed as a machinist in the Navy Yard and attending evening high school. Following treatment he took a trip to California, worked there a while, and later came East.

Although he had been classified 4-F because of his court record and sexual misdemeanors, he made every attempt to enlist in some branch of the military service, as he wanted to do his part in the war effort. He finally decided to leave home and is now working in a shipyard. He is completely on his own and has had many opportunities to expose himself. His parents informed me that he is making a good adjustment and has not given way, since treatment ended, to what patient once described as an "uncontrollable" impulse to exhibit himself.

FAMILY SETTING

Grandparents: The maternal grandfather, described as "nervous and excitable," deserted his wife. He was a teacher of religion. The paternal grandfather, also a very religious man, was divorced twice and the paternal grandmother divorced her first and second husband and had married the third time.

Parents: The patient's father, highly neurotic, a teacher of religion, is described by the patient as having uncontrollable spells of anger. He attempted suicide by taking an overdose of sleeping tablets and manifests pronounced sado-masochistic tendencies.

The patient's mother is also neurotic, afflicted with arthritis and, according to the patient, has "bad dreams," during which time she screams for help.

Siblings: The patient has one younger brother, who attends school and who, apparently, is making a better adjustment. His sister is 27 years old, married and has one child. She has never had emotional difficulties.

Relatives: One maternal uncle was reported to have been in a mental institution, while another, also a teacher of religion and separated from his wife, was reported to have exposed himself before his pupils and was discharged from his position.

From the above we see evidence of considerable hereditary tainting. The incompatibility of his grandparents; the neuroticism of his father and mother; an uncle who was psychotic and another who was an exhibitionist.

An important point should be made here: the patient first learned that his maternal uncle was an exhibitionist prior to the last time he exposed himself. His father conveyed this information to him (displacement of the father's own guilt) as if to say to his son, "You see, you are a victim of bad hereditary influences on your mother's side."

Shortly after treatment was started, the father presented himself to me, and stated that he wished to furnish me with information which he thought might throw light on his son's sexual problem.

The following is an abstract taken from the father's interview which the author thought important enough to reproduce.

"I came to see you to give you some information which may help you to solve my son's problem. My family life is a failure. I was brought up in a fanatic religious atmosphere. My marriage is the result of being deceived by a match-maker in the old country. There is no love between my wife and me. We considered a divorce but when I learned that she had become pregnant, we dropped the subject of divorce. We were both young when we were married. I was eighteen and she was sixteen. I feel that my son is the victim of our incompatible lives. I feel my wife doesn't respect me. At one time I was jolly and the life of the party. Now I am a dead man. She killed my spirit. In a way, I blame myself for my son's failure. As a result I am a very sad man and get frequently depressed. Life has no value for me."

The pronounced masochistic component in the father is self-evident. I suspected that he was concealing the main reason for his feeling guilty in contributing to his son's sexual aberration. My suspicions were justified, for the patient later revealed that his father would undress before him while talking to him after returning home from work.

More evidence of masochism is found in the father's statements:

"I was examined by a doctor and he said that I might drop dead at any time. I have a rapid pulse and I get terrible headaches and feel dizzy. That is another reason I do not care to live. I plan definitely to commit suicide. I once told my wife about

this plan and she said, 'What's the hurry?' If I commit suicide I would hang myself. I often think what impression it would make on her when she would see me hanging. About two years ago I took over 80 sleeping tablets in an attempt to kill myself. My wife told me that I slept for several days but I didn't die."

We see in the above passage the extent of the father's infantile sadistic component. By his suicide he wishes to hurt his wife.

The father's neuroticism is reflected in his sex incompatibility with his wife. His pronounced sado-masochistic trends apparently account for much of the unhappiness that exists in the home. The father's anal-erotic personality and the compulsive type of his neurosis are significantly reflected in the son's exhibitionism. There is considerable father-son identification. Both of them stress punctuality; both dislike noise and have a tendency to jot down trivial details on paper. The son likes to save old magazines in the cellar while the father likes to accumulate books of all kinds.

THE PATIENT'S RELATIONSHIP TO THE MEMBERS OF HIS FAMILY

Relationship to the father: Patient presents the following information regarding his father:

"My father should have given me some kind of sex education. I don't see much of him except on week-ends. Both my parents treat me like a 'sissy.' I like to play chess with my father and find ways of beating him. My father is a smart man. He is studying all the time. I don't like books. I can't concentrate. He is too severe. The more he insists that I do something, the more I feel like disobeying him. I am afraid of him. Once when I was talking to my brother, he asked me if I had moved my bowels. I kept talking to my brother. He got mad and took off his belt and whipped me. He often took out his pocket knife and would trim my finger nails with it. He did that up until I was eleven years old. Between the ages of three and five I slept with my parents. My sister also slept in the same bed. Until I was twelve, I slept with my brother and occasionally with my mother. After the age of twelve I preferred to sleep alone. My father would call me into his bedroom when he came home and insisted on talking to me. I would sit on a chair facing him and he would start to undress to put on other clothes. He would be naked. I did not like to look at his sex parts and would turn my head away. Sometimes when I was talking to my father in the bath room, I would see him

urinate. I often would urinate in the sink or bathtub while he used the toilet. Sometimes in the morning I would be washing when my father would come in and defecate. This happened almost every morning. This has been going on for the last six years. I was afraid of my father. He would use his strap on me. I often felt like running away from home. After an argument with him, I did not have any affection for him. He does not understand me."

In another passage we find greater evidence of patient's bipolar feelings toward his father.

"My father wanted me to memorize the Gettysburg address when I was six years old. I didn't want to. He would force me to study and get better marks. I did not like to have him tell me what to do. For six years he insisted that I get up at seven in the morning and then he would read the Bible to my brother and me. I did not like him to undress in front of me. When he would get mad and shout I hated him. Once he told me to lie down over the bed and drop my trousers down following which he strapped me over my backside with his strap. He did this about a half-dozen times, particularly when he learned that I had exhibited myself."

In questioning the patient as to what effect father's discipline had on him, he frankly admitted that it "encouraged" him to expose himself, to spite his father, to the extent that he was once tempted to exhibit himself in a temple which his father attended. His exhibitionism at this point represented also a rebellion against authority and against God.

We may question the father's motive in undressing before his son. Being frequently exposed to his father's nudity, has no doubt contributed to the development of the patient's own compulsive exhibitionism (father-son identification).

Relationship to the mother: The patient's mother shares in the responsibility of creating for the patient a neurotic home atmosphere as evidenced by the following revelations:

"Sometimes when I was in a bathtub taking a bath, my mother would come in to get a towel. Once or twice when I was taking a shower she would come in to urinate. I could hear her urinating. My father would do the same thing. I could see my mother wipe herself with toilet paper. When I would be shaving, my mother would come in to urinate or defecate. A few times when my mother was urinating she would call me and talk to me with the door open while she was still sitting on the toilet seat urinating. When I left the house in the morning and would come home in the

evening my mother insisted that I kiss her on the cheek each time. But I never liked it."

With the unfortunate exposure to psychic traumata of this kind, the development of the sexual maladjustment in the son was inaugurated.

Relationship to the sister: The patient states that he has never seen his sister in the nude. He denies ever entertaining sexual fantasies regarding his sister. He once put on his sister's panties as a child; beyond that he does not recall any incident involving sexual activities with his sister. The only suggestion of a sister involvement is a fantasy he has as a rule, prior to his exposing himself; it is the vision of a woman whose physical features resemble those of his sister.

Relationship to the brother: Patient's brother is four years younger and apparently endowed with more intelligence. He gets along well at school, takes music lessons and is the favorite of the family. The patient admits feelings of rivalry and envy. His brother wants to go to college and become a teacher like his father. Although the patient as a boy, has slept in the same bed with this brother, he denies having had any physical contact with him. He claims he once hit his brother with a strap and was punished for it by his father. He further states that his brother gets along with his father better, particularly in his lessons of religion given by the father.

PERSONAL HISTORY

Patient was born in New York City. The father claims that he was not on good terms with his wife during the pregnancy and believes that this may have had something to do with the development of his son's sexual abnormality. The patient attended school at the age of six. His teachers complained that he would often hit other children. His marks were below average. As a child he was shy, introverted and unable to make friends. He was afraid of thunder and after the age of twelve, preferred to sleep by himself. His family moved to Europe during the patient's adolescent years and then returned to the United States.

The father informs us that his son enjoyed making fires and once took real delight in setting fire to a trash can in his brother-in-law's work-shop. He once walked in his sleep, but there is no other evidence of somnambulism. He gets angry easily and claims that his memory is poor. He has the habit of saving trolley car

transfers, for no apparent reason. He often stares into space, has then a blank expression on his face. The parents also relate that he seems to lack any knowledge of sex fundamentals for it was as late as in adolescence that he asked how babies were born. This ignorance in sex matters is in keeping with an answer he once gave when asked why he exposed himself: "I want the girls to like me." (He believes in the magic powers of his phallus.)

The patient's father adds that his son is very religious, punctual and fond of music. He also thinks he has an inferiority complex as he seldom engages in conversation. He appears preoccupied most of the time. He responds to conversation by answering, Yes, No, Maybe, or I don't know. He enjoys reading the Popular Mechanics magazine, the comics, mystery stories, and likes to work with his hands. He doesn't smoke or indulge in alcoholic beverages, has a tendency to over-eat and does not particularly like sports. At an IQ test, the examiner ruled out mental deficiency. He has made a satisfactory occupational adjustment. As a machinist his work has been satisfactory. He likes work, has never been particularly neurotic about having to earn his living and seldom complains about his health.

VITA SEXUALIS

Early sexual recollections: Patient relates his early sexual experiences as follows:

"When I was eight years old, I played with two boys my age. They were brothers. Once, while we were playing in a small shack they told me to take out my penis, which I did. They probably enjoyed it. The other brother then went around the shack, put his penis through a hole and urinated right into my face. The older brother told him to stop it."

Having been instructed to expose his penis at the age of eight, he probably developed the idea that sex pleasure can be derived from "exhibiting" oneself. The traumatic experience of a boy urinating into his face was later transformed into urophiliac fantasies in which he urinates into a girl's face.

We learn that in childhood his sister was taking care of him and his brother. She took them to school, occasionally to the movies, and helped them with their school work as well as bought picture magazines for them.

The patient relates the following incident that occurred when he was ten years old:

"My brother and I took my sister's panties and put them on after we took our clothes off. Nobody else was at home. We went on the porch of the second floor after putting them on. (Patient claims he put one leg in the panties and his brother put his leg through the other leg opening. Then they proceeded to exhibit themselves in this fashion.) When we saw mother coming, we dashed into the house, took the panties off and dressed ourselves."

The above episode suggests a tendency toward transvestitism. In late adolescence he presented a day-dream in which he appeared dressed as a woman (sister-identification).

His voyeuristic tendencies, the twin-paraphilia of exhibitionism, manifested itself before the age of puberty.

"Two boys wanted me to join them in seeing a young girl, a close relative, taking a shower. I did without thinking whether it was right or wrong. We couldn't see through the key hole, so we tried from a window of the shower room. But the girl put something over the window and we could not see."

In exhibiting himself, the process is reversed. Patient gets gratification in trying to focus the girl's attention onto his exposed penis (a desire "to be seen" rather than "to see").

At the age of twelve while at a camp, he was induced to sit on a girl's lap. When he did that another boy exposed his penis before him. We see here a correlation between childhood bisexuality and exhibitionism. Also, by sitting on the girl's lap the patient placed himself into a better position of identification with the woman.¹ Both figures fused into one make a woman with a penis. Did he wish to see the penis in the woman?

One day, while at school, a boy sitting to the left of the patient took his penis out and showed it to a girl. She threatened to report the incident to the teacher. Patient claims this made a deep impression on him. (Fear of castration?)

Exhibitionistic episodes: The following is a list of episodes of exposure. The idea first occurred to him at the age of thirteen but he did not actually expose himself until a year later.

"When I was fourteen I exposed myself to a girl who was eleven years old. The girl told her mother and she told my mother. I was not punished for it. At the age of fifteen I exposed myself to a woman who was forty years of age. She was a stranger and

¹ A similar mechanism can be observed in Leonardo's composition of Madonna analyzed by Freud.

walking along the street towards me. She called the police and I was taken to the police precinct, where I was held until my parents came for me. The third time was in 1940 at school. I was sitting in the back row and showed my penis which was hard to a girl. She reported me to the principal who told my father. My father gave me a good strapping as punishment. The next time was also in class. This girl reported it to the police later and they came to my house and put me under arrest. My mother bailed me out. The judge sentenced me to the psychopathic ward of the local hospital where I was detained a month and released on condition that my family would place me under the care of some psychiatrist. I had exhibited myself several times in trolley cars and busses. I would sit in the back and when I saw some girl sitting opposite me, my penis would get hard. I would place a newspaper on my lap and would reach down, unbutton my pants, and when I caught her looking my way I would raise the newspaper. One day I noticed two girls sitting on a park bench. One was thirteen years old and the other around fourteen. They were eating their lunch. The thought of my wanting to expose myself came to me. I did not try to control the thought. I got an erection, unbuttoned my trousers and took my penis out in front of them and kept on walking. A motorcycle cop saw me and came after me. He locked me up and my parents had to get me out on bail. This time I had to pay a fine. My mother had hired a lawyer."

The patient tells us that his father would give him a penny for every day that he didn't expose himself. He remarked how "childish" this was for as a machinist he was earning good money. It represented more the father's own anal-erotic make-up. His father told him he should go to dances and dance with plain-looking girls, thinking this would help him overcome his feelings of inferiority. The patient resented this as humiliation.

Masturbation: Patient admits masturbating since the age of thirteen twice a week (this is the age when he first thought of exhibiting himself). He always experienced a feeling of guilt following masturbation which he considered as a transgression against his religious teachings.

Patient also admitted an attempt at auto-fellatio. He once took a sixteen-year-old girl to the movies. He claims he also kissed her once on the cheek, at a party. It was his first kiss. He has never exposed his penis before this girl nor has he ever made any sexual advances toward her. No other experiences with

the opposite sex. The patient claims he is too shy to make friends with girls.

SEXUAL FANTASIES

Patient submitted a number of fantasies which for the most part are concerned with paraphilias. There is considerable evidence of psychosexual infantilism.

A typical masturbation fantasy is the following:

"I see a young woman about the age of twenty-one. She is naked, has a good figure about five feet six inches and weighs 130 lbs. She must be in some kind of action like dancing, running, taking a bath or swimming."

In the next fantasy we find a component of transvestitism, as well as suggestive evidence of bisexuality.

"One time I had a fantasy of being dressed like a woman. This happened a year ago. I was dressed with high heeled shoes, stockings, silk pants, brassiere, slip, dress and hat and went out into the street."

In the above fantasy also, we see the disguised homosexual component—the desire to be dressed as a woman and walk the street (mother-identification).

In another masturbation fantasy he pictures a woman putting his penis in her mouth. While in another he is sucking a woman's breasts.

His urophiliac tendencies are expressed in the following fantasy:

"I masturbated with the picture of a woman drinking her own urine."

On several occasions he has had the following fantasy which is saturated with sadism. It reveals the nature of his homicidal inclinations:

"I have this sex fantasy many times during the day. I picture a woman naked, walking, running, or swimming. I put my penis in her vagina. I then kill her by drowning her after having sex relations with her. I put her in a cement block into a river. Sometimes I have fantasies of burying her alive instead, digging her up again from her grave and throwing her into water—other times I have her bleed to death or use a noose and hang her.—One time I had fantasies of throwing a knife at a naked woman.—Such fantasies give me a strong erection. I never ejaculate, however, while I have these fantasies.

The extent of these sadistic fantasies would make us suspect that the patient is a victim of much repressed hostility and that the sadism is a projection of his repressed hatred of the father (displaced in his fantasies by having the victim a woman instead of a man—transposition of the sexes.) The sexualization of the sadistic component takes place by linking the homicidal act with heterosexuality.

The following fantasy gives more evidence of his psychosexual infantilism and is perhaps a hang-over from the time in childhood when a boy urinated into his face. It is also associated with the actual psychic trauma of having seen on various occasions his mother urinate.

"I have fantasies of filling a bathtub full of urine and having her take a bath in it. Having her drink a glass of urine. Putting a few drops of urine in her tea and adding sugar to it. We play a game of animals."

In another fantasy he states that he is taking a bath in woman's urine. Another sadistic fantasy he relates as follows:

"I would force the girl to take her clothes off at the point of a gun or knife, blindfold her and tie her up and tear her clothes off and then have sex relations with her. I would then bite her breasts and later put my penis in her mouth having her suck it and swallow the semen."

We note the oral-cannibalistic trends manifested in his desire to bite the woman's breasts. There is reason to believe that urine may in this case represent blood, the patient's fantasy being connected with deep-seated repressed, atavistic (vampiristic) tendencies. The passive fellatio suggests a disguised repression of his own active fellatio desires. Patient once told how at work some of his fellow-workers requested that they would like to have patient perform fellatio on them, and how this would upset him to the extent that he wanted to kill them.

Patient states that he sleeps in the same room with his younger brother. As stated above, he is jealous of this younger brother. It was patient's request that he should sleep in a separate bed. This gives him a better opportunity to masturbate without his brother knowing it, and this also protects him against making any homosexual gesture toward the brother.

DREAM LIFE

The patient submitted only a few dreams. The following dream involves his younger brother:

My brother and I made, or rather wrote, some music and we wanted to play it in an orchestra, or at least to have a hearing to see how good the pieces are. We went from one orchestra to another and asked the leader to take us in, but they were too busy to listen. One day we came to one orchestra leader who like others didn't want a thing to do with it. We went home as usual in disgust. Just as we were leaving for home this orchestra leader called us back and after a brief thinking took us in from the side entrance to where the orchestra sat. The place was near a stage in a hall, in an auditorium or whatever the place was. He gave us our seats according to the instruments we played. My brother played the violin, which we happened to bring along at that moment (ordinarily he knows how to play the piano better than the violin) while I took the piano (which I hardly know). Before we had a chance to play, the alarm clock sounded off and I found this whole thing was just a dream.

"Playing music together" is a symbol of mutual masturbation. The orchestra leader represents the father who is indifferent. In the dream as in life, the patient often remarked that his father never paid much attention to him as he was always occupied with his studies. It also symbolizes the rivalry between patient and his brother for the father's approval. His wish to displace his brother is evidenced by the displacement in the dream—the brother playing the violin rather than the piano which is his best instrument. In the dream he has his brother play the instrument which he cannot play. The dream reflects the patient's feelings of inferiority toward his father (orchestra leader) and his preoccupation with the fact that the younger brother is the father's favorite. His wish for equality is represented by the fact that both compose a piece of music and that both are interested in getting a position with an orchestra. The auditorium is the public or rather the outside world for whom the patient must play or make an adjustment to. Not having an opportunity to play represents the frustration of "not being given a chance." The dream shows that the father is responsible for retarding the patient's desire to express himself (symbolized by a desire in the dream to express his emotions through music). Actually the father as well as the mother, through their neurotic handling of their son, have enhanced the patient's feelings of inferiority.

The patient presents another dream which runs as follows:

I was on my way to school. All of a sudden water began to

overflow the streets in the vicinity of which I was walking. The water rose as high as my knees. A few minutes later fish of all sort and color began to swim around me. One of the fishes was a swordfish and it followed me practically all the way to school. As soon as I was aware of it, I reversed my steps and ran back home. The swordfish still followed me. Just as I ran up the stairs to the house in which I used to live, the scene shifted to the cellar across the street from us. The water also in this cellar was knee high. The swordfish jumped from the top of the stairway to where I was lying down. While my family were watching from above the stairway the swordfish started to cut me up. Before he had the chance to finish, I yelled.

It is interesting that patient had this dream just at the age when he was entertaining fantasies of exposing himself (age thirteen). The fish is a phallic symbol which is swimming about him (penis exposed). The swordfish could well symbolize the father whom he fears and who is about to "cut him up" (castration fear). The fact that he is on his way to school represents his urge to expose himself while en route to school. Water again is a symbol of urethral fantasies. The cellar represents the subterranean strata of his mind (id cravings). His anxiety manifested by his yelling gives us a clue regarding his fear of the father. There is also an element of homosexual seduction in the fantasy, namely—"lying down" while the swordfish is about to attack him. The swordfish represents a penis capable of injury.

An anxiety dream he submitted hints at a guilt complex resulting from repressed incest fantasies about his sister.

I became frightened by thunder and felt that the corner of the room was going to fall down. My sister was sleeping in the same room.

He recalls how in childhood he once put on his sister's panties. Despite the fact that this is the only evidence we have of any sexual involvement, there is a strong suspicion that he harbored a desire to see his sister and mother in the nude. This would con-
form with what Gutheil states about dreams of exhibitionists: "Exhibitionism is, as experience teaches, based on the patient's unsatisfied desire to see some (tabooed) person undressed. In this unsatisfied desire the patient feels compelled to take the 'active part.' He tries to identify himself with the person who refuses to fulfill his desires. He attempts to do by himself what he really wants to be done by the tabooed person. In other words exhibi-

tionists are in reality unconsciously voyeurs. Small wonder that we find the true mental situation in their dreams."

PSYCHOGENIC MECHANISMS

Patient selected girls of puberty age. On several occasions his victims were middle-aged women (sister and mother substitutes). His penis was always in a state of erection prior to and during exposure. There was never an ejaculation during the act.

While he was aware of the consequences if apprehended by the police, he found the impulse irresistible. There was usually a feeling of regret following each exposure.

At the time of exposure the patient is in a semi-stuporous state. Restlessness sets in, followed by the fantasy of the girl's reaction to the exposure and then the actual exposure takes place. The patient has a tendency to stare at people. This staring complex, no doubt, is associated with the reaction to the nudity he experienced at home. He developed a "looking impulse" before he developed a "being seen" complex. Actually exhibitionism is merely a passive form of voyeurism. Having experienced pleasure in looking at his father and mother in the nude he thought girls would derive a similar pleasure in looking at his penis. "To be seen" thus became his urge. The drive behind his paraphilia represented the result of a repression of incestuous fantasies directed toward his mother and sister. The desire in late adolescence to expose himself was an urge to re-experience what he once experienced in childhood. "The impulse to exhibit is an erotic imperative of the past" (Stekel).

Another explanation lies in the interpretation of the anti-social act as an expression of bipolarity toward the hostile father whom the son regarded as a "religious hypocrite."

Patient's habitual exhibitionism was the sequel of his psychic traumata. We know that it is common to children but most of us outgrow it. In the neurotic we find evidence of a libido fixation on this level.

Stekel describes a case of exhibitionism in a man who was exposed to a similar psychic trauma during adolescence as follows:

"The patient's mother washed herself in his presence, completely exposing herself and often walked about naked before him, thus exciting him and prematurely arousing his sexual desire. Under the influence of these experiences he began to masturbate when he was twelve years old."

Our patient attempted to over-compensate his feelings of inferiority by developing an unconscious penis-narcissism. In exposing his penis before women he was competing with his father. His objects were mother and sister substitutes. He wanted to show them that he had a better penis than his father or his brother.

His parents, particularly his father, had taught him that nudity was not shameful. Patient put this into practice.

His exhibitionistic acts generally followed periods of abstinence from masturbation. He confessed that on many occasions he masturbated while looking into a mirror. We see how the libido became fixed on the "eye" level. (The eye became the leading erogenous zone.)

The pronounced sadistic component present in the patient tends to lend support to Bloch, Freud and Merzbach that "exhibitionism is a weakened form of sadism."

EPILOGUE

Following the completion of his analysis, he was advised to leave home and venture out into the world on his own. Parents hear from their son who is now employed in a city several hundred miles from home. Judging from his letters, he is making a good social and economic adjustment with no indication of any sexual difficulties. The exhibitionism stopped.

SUMMARY AND CONCLUSIONS

1. Exhibitionism as a psychic phenomenon is amenable to psychotherapy.
2. The urge to expose oneself sexually is a form of compulsive behavior. "The exhibitionist is a very sick individual whom it is useless to punish legally but who instead must be treated psychotherapeutically" (Karpman).
3. The inferiority nucleus played an important role in this particular case. Patient was striving for recognition and attention which he did not get from his parents. He was treated as a child so he decided to act like a child (psychosexual infantilism).
4. The patient's anti-social tendencies represented a bipolar reaction to the hostile father (a psychic castration of the father as a defense against being castrated by the father).
5. Rivalry between the patient and his younger brother, the favorite.

6. The patient manifested a pronounced anal-sadistic component. It is based on the repressed hostility against his parents which found expression in his anti-social acts.

7. The religious discipline emanating from the patient's father served to accentuate the conflict between his instinctive cravings and his moral censorship.

8. The patient had a bipolar attitude toward school; he made a deliberate attempt to be "unlike" his father, the scholar.

9. There is some evidence of a psychosexual attachment to his mother, disguised in the patient's fantasies of the opposite sex. He once stated that the forty-year-old woman before whom he exposed himself resembled his mother. The younger girls were sister surrogates. "Obliged to repress his incestuous cravings, the child's surging sexuality is led into aberrant avenues of expression with exhibitionism as one of its adaptations" (Karpman).

10. There was evidence of unconscious homosexual leanings.

11. Patient's sex life as a whole represents a marked psychosexual infantilism.

12. Secretiveness, bashfulness and fixed staring became characteristic behavior anomalies.

13. Psychoanalysis attempted to bring to the attention of the patient the psychogenic mechanisms responsible for the development of his compulsive behavior (the Oedipus situation, the inferiority, the bipolar feelings toward the father, the homosexual leanings, the psychosexual infantilism, the penis-narcissism, the sadistic component, etc.).

14. A satisfactory therapeutic result has been achieved as evidenced by the fact that there has been no recurrence of exhibition within the past years.

BIBLIOGRAPHY

1. Ellis, Havelock: *Studies in the Psychology of Sex*. Davis Pub. Co., Phila., Penna., 1933.
2. Freud, S.: *General Introduction to Psychoanalysis*. Garden City Pub. Co., N. Y., 1938.
3. Gutheil, E.: *Language of the Dream*. Macmillan Pub. Co., N. Y., 1939.
4. Karpman, Ben: Psychopathology of Exhibitionism. *Psychoanalytic Review*, Vol. XIII, No. 1, Jan., 1926.
5. Krafft-Ebing: *Psychopathia Sexualis*. Physicians and Surgeons Book Store, 1934.
6. Moll, Albert: *The Sexual Life of the Child*. Macmillan Co., N. Y., 1929.
7. Moll, Albert: *Perversions of the Sex Instinct*. Julian Press, Inc., 1931.
8. Stekel, W.: *Essays on Sex and Psychoanalysis*. *Exhibitionism*. Eugenics Pub. Co., 1932.

ANTHROPOLOGY AND PSYCHOTHERAPY

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Psychotherapy, particularly psychoanalysis, proceeds from a number of assumptions which largely derive from the understanding of the importance of man's early immediate environment—the family. The relation toward his family is man's emotional matrix. The concept of the superego presupposes a certain set of conditions which are valid within the scope of a particular culture; but is the freudian concept of the family a *sufficient* basis for the explanation of basic emotional disturbances?

It is worthwhile to compare the vicissitudes of groups who came from different emotional matrices with those of the "freudian family" and its concomitant emotional difficulties. Freud in his studies on the biological implications of instinctual life relied a great deal on what anthropology at his time had contributed to the understanding of the primal human horde. He attempted to evaluate in man the relation of ontogeny to phylogeny, as well as the fate of cultural influences upon the primitive man.

Since Freud's time, anthropologists have made field studies on newly discovered tribes and formed new concepts about human organizations. Hence the question naturally arises: What bearing, if any, do these new anthropological data and concepts have on contemporary psychoanalysis and psychotherapy?

It is the purpose of this article to consider generally and specifically the anthropological contributions toward the understanding of psychotherapeutic difficulties. The greatest hindrance to getting well is the patient's unwillingness to assume what in his society is called maturity, and to accept the demands of a socially established and conditioned superego. Conversely, the greatest aid to getting well through a psychotherapeutic process is the patient's willingness to assume the adult rôle in his society, and the analyst's own fully understood and mature superego, which makes possible a sound, progressive adaptation within a possibly ever-changing society. However eager a patient may be to get well: he cannot do so, unless he knows explicitly what he is supposed to be as a mature and full-fledged member of his society; and the analyst will be

limited in his effort to help, unless he knows explicitly the demands of his own superego and unless he knows in what way his own superego is contrasted with the structures of the superegos of other individuals and other cultures.

Superego is known to be that part of the psychic apparatus which mediates between ego drives and social ideals, acting as conscience; it may be partly conscious and partly unconscious. The demands of the superego may or may not be considered sound in a society under consideration. *But is there a superego that would be considered sound in every society?* And if that is not the case, what should a "sound" superego be like?

Generally speaking, we see things and concepts clearly only against a contrast. As it is with relatively simple, concrete matters, so it is also with complex conceptual constructs, such as the superego. A psychotherapist rarely has occasion to see a patient with a cultural background totally different from that of his own society. Hence we do not become aware of such a patient as set against a different civilizational background; and of what the significance and meaning of his behavior would be in another society.

In order to become so aware, and thus to see the patient's mentation as clearly as possible, it is necessary socio-analytically to study a society that is completely different from one's own, for instance, a polyandrous society, in which one woman customarily marries many men. Prince Peter of Greece has made an extensive study of several polyandrous societies; his work "Tibetan, Toda, and Tiya Polyandry: A Report on Field Investigations"¹ will be the basis of the discussion on polyandrous communities.

There are two ordinary forms of polyandrous marriages known in Tibet, namely *bagma* and *mappa* marriages.² In the *bagma* marriage a woman marries all the brothers of one family, regardless of their ages; she may even marry a boy of that family born after her marriage with the other brothers. In the *mappa* marriage, the woman marries men not related to one another. The usual type of marriage is the *bagma* marriage. However, in case there are only daughters born in a family, while the younger ones marry as usual, the oldest daughter consummates a *mappa* marriage; that is to say, she chooses any available man, even though he

¹ By H. R. H. Prince Peter of Greece, Transactions of the New York Academy of Sciences, April 1948, pp. 210-225.

² Ibid., pp. 211-18.

may not be blood-related to her other husbands. In the fraternal case the marrying brothers, related through the same father, provide the property; in the non-fraternal case, the oldest daughter provides the house and becomes master of the house.

As to the Oedipus situation, or the familial soil out of which it grows, the following may be said: *Property considerations determine the sex and marriage customs, and in this way the morals*, of the Tibetan social organization, just as in the Western world the property rights of the father determine the particular family life of the Western organization, with its unavoidable Oedipus complex, marriage customs, and morals. In Tibet, the house, being the axis around which the social system revolves, comes into the hands of the younger generations. " . . the parents must be satisfied to live on an allowance, or on a small part of the property which is put aside for them."³ In the Western civilization, the parents keep house, property, and power, and the younger generation has normally to leave the parents' house and strike out for itself, independently as we say, of the parents. In Tibet, the parents try to ingratiate themselves with their sons. "The fathers are often somewhat afraid of the sons, because as soon as the sons become married, the parents have to leave the house. Thus, the parents try to ingratiate themselves with their children so that they will be left a sufficient amount of property on which to live when the children marry." Of course, in our society, the opposite normally happens. The children try to ingratiate the parents so that the latter will give their property to the children in the form of an allowance, a dowry, or an inheritance. The morals are concomitantly different. In Tibet, the practical command is that the parents honor their children; in the Western world, that the children honor their parents.

Certainly the Tibetan id, ego, superego, and reality configuration must be different from ours. It would be of the utmost importance to study whether or not their system leads to greater psychological strains and more involved neuroses than does our system. Young Tibetans do not need to leave home to make a living; non-polyandrous societies compel their children to leave home. A man by the name Tock-tuck, in Leh, Tibet, reasoned that if Europeans were polyandrous they would not be so restless, they would keep their property together, would have enough to go

³ Ibid., p. 214.

around, would stay wealthy at home, and would not need to fight with other peoples in order to get colonies. In other words, sons would not hate fathers; and, hence, need not flee their "fatherland"; and, thus, in terms of a polyandrous Tibetan society, would not by necessity be driven to immorality.

Morality is very high among polyandrous people. This is especially the case with older individuals, although they suffer under the system. These older men complain that nowadays the younger people have become lax and immoral about following the demands of the polyandrous society. Where morality is both high and enforced, we should expect to find an overly-strict superego, unhappiness, and neurosis. This seems at present to be the case among polyandrous Tibetans. Thus, many a young man leaves his brothers and marries an heiress by way of a *magpa* marriage. From the point of view of polyandrous morality, such a marriage is unjustified for the man. Unless love should enter, such an unjustified *magpa* marriage could only indicate unhappiness. In case an individual would marry, after *bagma* fashion, the same woman his brothers took to wife, he would fear to become unhappily dominated by older and stronger men.

Jealousy among brothers, with neurotic consequences, has also been observed. One young man, in love with his wife, committed suicide, because she preferred to have sex intercourse with his brothers. Another young man, for similar reasons, developed an hysterical paralysis of one leg. After the deaths of his brothers he got well.⁴

Incidentally, a third type of polyandrous marriage, a *tchamadoong* marriage, throws an interesting sidelight on the difficult problem of the oath. The "names" a man swears by illuminate his taboos. One swears by greatly revered and greatly despised objects or ideas. Prince Peter writes: "I have caught my caravaneers openly insulting central Tibetans as being *tchamadoong*-practicing. Also, when they are playing dice, I noticed that sometimes they invoke the *tchamadoong* to produce luck for them, so that she is a kind of double figure to whom they cannot be entirely indifferent: they despise her and yet at the same time she can bring them luck."⁵ But who is *tchamadoong*, revered or despised?

Tchamadoong is a woman married to the brothers of a family

⁴ Ibid., pp. 216-217.

⁵ Ibid., p. 218.

and to their legal father, after the wife of these legal fathers has died. In such a case, the physiological daughter of one of the fathers is:

- a) to this father, physiological and legal daughter and legal grand-daughter;
- b) to the other fathers, legal daughter and grand-daughter;
- c) to the sons, physiological sister and legal child.

The wife is "tchamadoong," revered and despised, superhumanly projected or conceived, as an object to be relied on for good, or to be held responsible for evil. So much for the psychology of swearing among the West Tibetans, who, like everyone else, swear by that which is superhumanly projected and ambivalent.

We will understand polyandrous society if we postulate the following: *Incest is less dangerous than aggression*. Then the rest follows, as theorems do from postulates. Prince Peter says: "These [polyandrous] people feel that a practice of aggression, of rivalry between brothers, is more dangerous than the custom of sharing one woman, which has led to the establishment of a community in which it has become compulsory to live in this [polyandrous] fashion."⁶ The fact that the custom has become *sociologically institutionalized*, that is, obligatory and compulsory to the individual, indicates fear due to a repressed desire; namely, the desire to become a rival of the brothers for a woman. As mentioned above, when this desire is not fully repressed it may return in the form of neurotic reactions.

The author states that polyandry presents a solution of the Oedipus complex. However, the following seems to be a more complete statement: Polyandrous society has solved not only the Oedipus conflict and the conflict in the father, who loves, envies, and hates his son, but also other familial complexes. Rarely do we consider these latter complexes. It may, therefore, be permitted to refer in this connection to the work of Ian D. Suttie⁷ who writes:

" . . . Freud in his social theory has concentrated almost exclusively upon:

- (a) The son's precocious sexual jealousy of the father's right to the mother—Oedipus Complex;
- (b) The woman's jealousy of the 'superior' male sex organs—Penis Envy.

⁶ Ibid., p. 225.

⁷ Ian D. Suttie, *The Origins of Love and Hate*, Kegan Paul, Trench, Trubner & Co., Ltd., London, 1945, pages 109-111.

"To each of these jealousies it seems to me there is an equally important complement. Thus, corresponding to (a), we have (c) the father's regressive jealousy of the child's nurtural possession of the mother—the 'Laios' or 'Ouranos' Jealousy and (d) corresponding to (b), the male jealousy of the woman's power of producing and nursing the child, i.e., the Zeus Jealousy."

There is also sibling rivalry. In short:

Oedipus Complex of son: son hates father, because father possesses mother;

Electra Complex of daughter: daughter hates mother, because mother possesses father;

Laios (or Ouranos) Complex of father: father hates son, because son possesses mother;

Penis Envy of castrating mother: woman hates man, because the man has a penis (alone can urinate standing, etc.);

Womb Envy of castrating father: man hates woman, because the woman has a uterus (alone can bear children, etc.);

Cain Jealousy: siblings hate each other.

"The fifth form of jealousy, (sixth in list above—E.D.) that of Cain for Abel, seems to me by far the most important in the process of socialization, if only because it is *biologically* (italics mine—E.D.) inevitable (except perhaps for the youngest children) and because it must, under primitive conditions, appear very early in life."⁸

Polyandrous societies appear to have solved the Cain Jealousy remarkably well; so well that quarrels between brothers seem rare—none has a legal advantage over the other, all possessing in turn the same wife. Thus, by way of a *tertium cohabitationis* (Stekel), they are also binding their latent homosexuality, i.e., they are possessing each other. They love the same object and are being loved by that same object more or less equally. Hence, there is normally no occasion for unresolved aggression.

The purpose of studying cultures other than our own is to gain a contrasting insight into our own cultural demarkation lines. Polyandry clearly shows that peoples with morals very different from ourselves can also survive. They show, in particular, that the familial situation inviting hostility rather than amiability has been solved in different ways. While polyandry does not seem a com-

⁸ Ibid.

plete solution to the problem of preventing familial hostility, it makes one wonder if any of the highly organized societies of today—East or West—has found a better one; and, if not, what consequences this failure may have for national and international affairs.

Furthermore, *repressed hostility at home means not only war abroad, but also war against one's self: neurosis*. It is the latter that we shall now investigate. As we do not have systematic health reports on the Tibetans, we will have to turn for information to other societies, the Guameese and the Okinawans.

Unfortunately, no somato-pathological investigations have been made on polyandrous peoples. This is regrettable for the following reasons:

If we are right in our opinion that our societal set-up causes psychoneurotic diseases and that psychoneurotic conditions cause psychosomatic diseases, then different societal set-ups should cause more or less severe, or different, or no, psychoneurotic conditions, and these should cause more or less severe, or different, or no, psychosomatic diseases.

While we have no publications on Tibetan autopsies whereby to check this opinion, we do have such a publication on the Japanese Okinawans⁹ and another paper comparing the Japanese Okinawans with the Christian Chamorros of Guam Island.¹⁰

Commander James C. Maloney compares Christian Chamorros with non-Christian Okinawans. He comes to the following conclusions:

"For some ethnic groups the Christian religion, with its projections, masochisms, identifications with Christ, Mary, etc., " . . . becomes confluent with or subjectively extends neurosis . . . many persons become unable to distinguish between themselves and Christ . . . the 'little son' being mutilated by surgery." This was the case with the (Christian) Chamorros, who were facile candidates for hysteria, fainting spells, autonomic crises, neurotropic dermatoses, asthma, etc. Children screamed easily, and mothers behaved as if " . . . they were afraid of something, were afraid of public criticism."

⁹ Commander P. E. Steiner, M. C. (S), USNR, "Necropsies on Okinawans," *Archives of Pathology*, Oct. 1946, Vol. 42, No. 1A, pp. 359-380.

¹⁰ Commander James C. Maloney, M.C., "On Oriental Stoicism," *American Journal of Psychiatry*, Vol. 103, No. 1, July 1946. Or see an abstract by the author of this paper in *American Journal of Psychotherapy*, Vol. I, No. 1, Jan. 1947, pp. 123-124.

The non-Christian Okinawans behaved differently. They seldom became psychoneurotic. The youngest school children suffered finger punctures and the dentist's drill without protest. One woman permitted a breast abscess to be deeply incised while she was fully conscious. And yet this stoicism is not present at birth, but is a product of *acculturation*. The resultant calmness differs from the studied calmness of other peoples, which requires the utmost energy suppression. Energy being indestructible, suppressed energy "canalizes physiological pathways neither designed nor adapted to its use." The resulting stresses on tissue induce demonstrable structural changes. This dynamism embraces the most fundamental evocative of psychosomatic disease. The Okinawan, free from psychosomatic disease, has no emotional suppression, conscious or unconscious. He is brought up in a culture which is neither the expression of a psychoneurosis nor has a neuroticizing effect.

Let us now take up the autopsy findings on the non-Christian Okinawans, as reported by Steiner. His findings and conclusions are, in part, as follows. "... these necropsies on Okinawans reveal differences from what would be expected in a similar series in the United States. . . . The most striking finding was the low incidence of retrogressive and degenerative changes. *Senility* (italics mine—E.D.) came late and to a moderate degree or not at all, and the lethal sequels in the brain, the kidneys and the heart were never seen. Hypertensive cardio-vascular-renal disease was not seen. . . . After the life of these people had been studied, two possible etiological factors appeared outstanding in explanation of these observations. They were: (1) a low tension, placid, although physically strenuous life and (2) a simple, predominantly vegetarian diet." Also, "There was a suggestion of excellent endocrine balance in the absence or the low incidence of hirsutism in women, pathologic obesity, thyroid disease, diabetes, cystic diseases, of the mammary gland, fibroids and endometrial disease of the uterus, and nodular hyperplasia of the prostate and the adrenal glands. . . . There was no disease of the stomach except ulcers; these were acute and may have been related to the psychosomatic stress incidental to the bombing and invasion. There were no scars of healed peptic ulcers. . . . Endocrinologically, these people appeared to be remarkably well balanced. They were highly fertile. Disease of the thyroid, parathyroid, pituitary and adrenal glands,

the pancreas and the gonads was either nonexistent, rare or unrecognized. . . . There was no instance of pathologic obesity and no hirsutism in women. The thyroid glands were small and without nodules or adenomas; only two contained colloid cysts. These people had no *acne vulgaris*.¹⁰

Steiner explicitly states that in order to understand the low incidence of retrogressive and degenerative diseases it is necessary to study the life of the Okinawans. Such information is now available in the comparative study of the Japanese Okinawans and the Americanized inhabitants of Guam, known as the Chamorros, reported above. It strongly suggests that it is the socially well-regulated, though physiologically strenuous, life of the Okinawans which explains their comparative freedom from psychoneurotic and psychosomatic diseases; and that it is the American tempo of life which causes them in our culture and in those who have accepted our ways of living.

It is evident, therefore, that a study of American life from the standpoint of a cultural anthropologist is of the highest importance. Such a study has been made by Geoffrey Gorer.¹¹ The following is a critical partial account of Gorer's anthropological study of American life.

A person who grew up in a Tibetan polyandrous society, or a Guamese (or, for that matter, a German) patriarchal culture must obviously be treated differently from a person who grew up in the U.S.A. (or, for that matter, any other society) whose members, if Gorer is right, share "the belief in the superior moral nature of womanhood."¹² In other words, the superego of a polyandric Tibetan, a patriarchal Guamese (or a German) is to be expected to differ greatly from that of a one hundred percent American. For instance, in a patriarchal society the girl is more easily conditioned to develop an inferiority complex; this is a well-known Freudian fact. By way of proof that Freud was right only for his Germanic (patriarchal) culture, we may cite Geoffrey Gorer concerning the American (matriarchal) culture with due consideration of his oversimplifications and generalizations. ". . . All Americans acquire a predominantly feminine conscience; and this faces the little boy with a dilemma which his sister does not experience

¹¹ Geoffrey Gorer, *The American People*. W. W. Norton & Co., Inc., New York, 1948. 246 pp.

¹² Gorer, *op. cit.*, p. 103.

ience. Because of the encapsulated mother, the little boy doubts his masculinity, whereas the little girl is reaffirmed in her femininity. To prove to himself and to the world that he is a real 'he-man' (the reduplication in the term is in itself suggestive) the little boy has to be more strident, shout and boast more, call more attention to himself than his sister need. American children of both sexes are brought up very similarly, by and large face the same dilemmas, and acquire the same type of character; but all the over compensations for insecurity—and a great deal is demanded of American children, up to the very limit of their powers—are far more developed in the boy."¹³ This superego construction leads according to Gorer the one hundred percent American to many odd behavior patterns: "The lives of most American men are bounded, and their interests drastically curtailed, by this constant necessity to prove to their fellows, and to themselves, that they are not sissies, not homosexuals."¹⁴

The way a cultural anthropologist approaches the problems of disturbed social living is of particular interest to the psychotherapist when problems of *acculturation* and *assimilation* present themselves. In such a case we can assume *not a faulty adaptation to workable ideals but an attempt at adaptation to ideals no longer workable*. For instance, a neurotically-patriarchical German youth may have proven maladjusted by his disobedience to authority, which disobedience is considered abnormal; whereas the American youth is expected to express himself freely toward an authority, which in his culture is conceived of as directly or indirectly representing "father."

Thus: "When school starts, the mixed neighborhood play group typically gives way to gangs entirely or predominantly of one sex; and these gangs continue up to, and in some cases through, adolescence. The gangs may engage in almost any kind of activity compatible with the strength and interest of its members; but nearly all the boys' gangs have one feature in common: they engage in illegal or extralegal activities. Most of these activities are harmless: robbing orchards in the country, trespassing on empty buildings, trying to get into circuses or baseball parks without paying, smoking cigarettes made of corn silk, using dirty words and engaging in sexual experimentation, staying away from school and avoid-

¹³ Gorer, op. cit., p. 94.

¹⁴ Ibid., p. 129.

ing the truant officer . . . cheeking policemen, and the like. What is important about these activities is that they are not only tolerated but expected and praised by the adults, especially the fathers; this successful flouting of authority is a sign of independence, of growing manliness; a boy who never attempted to do so would show grave signs of turning into a sissy."¹⁵

How utterly different this type of U.S.A. *social-expectation-behavior* or *superego-conditioning* is from that of a Tibetan or Okinawan or European!

To show the importance of anthropology to psychotherapy we will mention only one more psychotherapeutically important institution. This institution is unique to American life; its potential acculturally induced psychoneurotic effect can hardly be over-estimated. It is the social institution of *dating*. In a way it is the climax of the life of a one hundred percent American. What is peculiar about dating? "Dating," Geoffrey Gorer states, "is idiosyncratic in many ways, but especially so in that it uses the language and gestures of courtship and love-making, without necessarily implying the reality of either. The overt differences of behavior which distinguish 'dating' from courtship are so slight as to be barely perceptible; yet only in rare cases, and those involving unbalanced people, does confusion result—when both parents are American."¹⁶ Obviously a psychotherapist can prevent a familial breakdown between, say, strict German parents with their superegos and their Americanized "dating" children, only if he is explicitly familiar with the nature of dating.

Conclusion: It has been the purpose of this paper to raise questions concerning the possible fruitful collaboration of anthropology and psychotherapy. To this purpose the following points were made:

1) Polyandrous societies show ways of solving the Oedipus Complex, as well as the Laios, Cain, and related complexes, totally different from our own ways; thereby they bring out in high relief our own familial difficulties.

2) Guam and Okinawan cultures differ in such a way that the occurrence of psychoneurotic diseases in one and their absence in the other must ultimately be related to the differences in their respective cultures.

¹⁵ Gorer, op. cit., pp. 101-102.

¹⁶ Gorer, op. cit., p. 109.

3) Pathological autopsy reports on Okinawans substantiate the belief that the mode of social life determines whether in a given society psychoneurotic and psychosomatic diseases are prevented or not.

4) The anthropological set-up of the United States was briefly discussed and an attempt made to show that changes in *sociomental* attitudes are necessary if psychotherapy is to succeed in what it attempts to do, namely, to generate such an emotional life in an individual that thinking, willing, and acting can become completely adjusted to the increasingly difficult requirements of a changing human society.

As developed, discussed and summarized in the previous pages each of the considered cultures shows positive and negative values. The scientific account of Prince Peter of Greece showed this for polyandrous people; of Steiner and Maloney for Guamese and Okinawans; and the impressionistic account of Geoffry Gorer for the American people. It seems that the scientific and impressionistic evaluative anthropological-psychotherapeutic work is only at the beginning of its career. Most of the work remains to be done. It ought to be done by applying the scientific method to whatever can be known by way of the scientific method; by daring to evaluate the scientific findings in terms of a constructive future psychotherapy, even though such evaluation may suggest a change of our opinion as to what constitutes a good society.

REMEDIAL TEACHING AS THERAPY

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Failure to make adequate school progress is frequently the immediate reason for seeking psychological help. Parents who have been unwilling or unable to recognize emotional problems in their children will not usually show this resistance toward facing the fact that they are having difficulty in school. This is understandable. The average adult today has some awareness of the connection between emotional difficulties and parent-child relationships. Often their knowledge in this field is sketchy and they are likely to feel it is their fault if the child is maladjusted. This leads to feelings of anxiety and guilt with the related resistance aroused by any effort to bring these feelings to awareness. They are likely to react differently, however, in the case of subject difficulties. Here they can at least share the blame with the school.

Many parents will in the first interview volunteer: "I know it must be my fault." This, of course, does not imply that they are by any means ready or able to recognize their share in the development of the difficulty. Many parents seem, however, to be subconsciously aware that they are somehow involved. It is important to relieve these guilt feelings by maintaining a non-directive attitude in all interviews with parents so that they may realize that there is no question of placing blame but rather a cooperative effort to understand the interpersonal relationship involved.

Since difficulty in school often prompts parents to seek psychological guidance, remedial teaching can be an important phase of therapy. School difficulty is the presenting problem of which both parent and child are aware. Usually, when the child is asked how he feels about coming and in what way he feels he needs help, he will answer that he needs help in reading or arithmetic. These are the difficulties he encounters in his job, going to school. Since this is a felt need, it is a good starting point and one which parents can also face. As the program progresses the related emotional problems will, under suitable guidance, come to the fore and the sessions are likely at times to become predominantly psychotherapeutic, while remedial teaching takes a secondary, but still

important role. As one eleven year old put it, "Let's not do arithmetic today, let's talk. Today I have something to talk about."

Even in the case of a child referred because of recognized emotional difficulties, there is likely to be some related difficulty at school. It is important, therefore, in working with children or adolescents to start with a clinical diagnosis of mental, educational and emotional factors. Needless to say, it is also necessary to obtain as complete a history as possible and a report from the physician as to present state of health. A psychiatric opinion may also be indicated.

The historical background is best obtained from the mother before the first contact with the child. At that time the mother is likely to be most cooperative and anxious to give a full picture, especially of her own reactions. It is also helpful to get as much information as possible from the school.

Work with children having school difficulties invariably reveals related, if not causative emotional factors. Often these emotional difficulties are secondary to very early warping experiences with significant adults in the environment. Even though the basic cause is rarely found in the school situation, much that happens in school acts as additional pressure which, taking root in the soil of early warp, threatens to develop into full blown emotional maladjustments.

It is true that the young child entering school brings with him a basic personality structure built upon constitutional predispositions and environmental experiences. Still, there is much that the school can do to neutralize or lessen some of these effects and prevent the development of others. Preventive measures are as important in the field of mental health as they are in physical health. In fact, modern studies in psychosomatic medicine teach us that the two are closely interrelated.

What then can the school and home do to foster mental health? Foremost seems to be the provision of a situation in which the child feels free to develop according to his own individual pattern. Somehow many educators have taken over the time-old belief that children have to be forced to learn. This implies that the child is naturally indolent and an iron hand is necessary. Even in many modern progressive schools the basic philosophy seems to be that all sorts of artificial incentives are necessary. It has been my experience that all children are anxious to learn and enjoy learning,

if given a chance to do so. There is a natural drive toward physical and mental health and growth. If this were not true all education would be a hopeless task. Fortunately this basic drive toward growth is amazingly resistant to unfavorable environmental factors. Still, there is much that can be done to foster this natural growth and to help it over obstacles put in its way, even though unwittingly. A school program oriented toward individualized progress can do a great deal toward preventing or overcoming specific subject disabilities. The child with more severe or accumulated difficulties requires individual help.

As mentioned above, it is important in individual work to obtain an extensive history from parents and school. It is helpful here to contact as many significant individuals as possible, and the father as well as the mother, the school head, present and former teachers and the school psychologist if one is available. This history will be helpful in forming a picture of the development of the present situation and will also reveal related factors in present and past interpersonal relationships at home and in school.

The physical examination previously mentioned should include the visual and auditory fields as well as general health and developmental factors. A referral for psychiatric or neurological examination may also be indicated. We would in most cases proceed next to apply a battery of clinical psychological tests with the aim of getting as well rounded as possible a picture of the present situation. Needless to say, these measures will be used as an aid in clinical diagnosis and not as ends in themselves. We will not be interested in scores as such, but in arriving at a comprehensive picture of the basic and dynamic factors related to the particular presenting problems which should be viewed as symptomatic rather than causative. The battery of tests would vary to meet specific needs and would include individual measures of intelligence, some performance tests, the Rorschach Test, tests of school achievement and any specific diagnostic tests indicated. It has been my experience that such a testing program is not only extremely helpful in arriving at a well-rounded picture but also acts as a help in establishing a good relationship and a starting point for therapy. Children and adolescents usually find these tests interesting and look upon them as games.

The test findings should be discussed with the parents in more or less general terms, oriented toward acquainting them with the

implications for them, the school, and the therapist. Contacts with parents should be considered as therapeutic in themselves and should be non-directive. Interviews with parents after therapy has started are helpful but should be planned only after discussion with the child and only when the child feels that they present no threat to him. It may sometimes be necessary to postpone such interviews until the child has gained confidence in the therapist.

The child should also be given some opportunity to discuss the test findings and especially encouragement to express his attitude toward the program. He must know that he is the important person in this program and realize that it is undertaken in order to help him in any way that he feels he needs help. Only with such a clear and frank understanding can a cooperative program be initiated. Even the very young child will soon realize that the therapist is working with him according to his expressed needs and is not another pushing, fault-finding adult. One little boy of nine with whom I was recently working, remarked, after unburdening himself of some guilt-arousing experience: "You wouldn't tell that to anybody, would you? I know you're on my side, that's what you're for!" Children are amazingly able to "catch on" to what therapy is, if given a chance.

It has been my experience that a remedial teaching program can be just as therapeutic as one having a play orientation. In fact the use of play techniques is often a helpful adjunct in a remedial program. The remedial teaching should be viewed as an avenue of approach to related emotional difficulties rather than as an end in itself. Since the subject disability is the child's recognized problem, it affords an avenue of approach to his emotional difficulties of which the learning problem is usually only one manifestation.

The psychologist carrying out such a therapeutically oriented remedial program will have to be familiar with diagnostic and remedial techniques as well as psychotherapeutic procedures. The program will, nevertheless, be quite different from one carried out primarily as a remedial teaching program. In both types of program the subject disability is the starting point and both will aim at overcoming the disability. The major orientation, however, in the therapeutic program will be toward improving the child's emotional adjustment in the realization that the symptom, reading or arithmetic disability, will thus be incidentally taken care of.

The child who is recognized as having a reading or arithmetic disability will inevitably have been exposed to repeated experiences of failure. This failure to keep up with his classmates is in itself bound to bring emotional difficulties to the fore. The child who has developed an armor of apparent indifference will be likely to resort to troublesome behaviour in an "I don't care" attitude. Although this child needs help, he is not so badly off, from the mental hygiene point of view, as the child who develops feelings of inadequacy, guilt and rejection. The first child is acting out his feelings of hostility engendered or aggravated by the reaction of school and home to his failures. The second child has primarily turned these hostile feelings in toward himself and accepts the critical and depreciating attitudes of teachers and parents. What both children need is a chance to experience success and acceptance in the very area where they have failed. Both have arrived at a point at which they are unable to use their abilities because of complicating emotional difficulties. The therapeutic remedial program must therefore be planned and carried out on the basis of individual needs, both educational and emotional.

If a battery of tests reveal that the child is mentally retarded, referral to a special class or special school is advisable. It is not intended to imply that the mentally retarded child may not also be in need of a therapeutic program. The basic need of this child, however, is an environmental situation which is equipped to provide a program geared to his possibilities. Such placement should of course be made only after a very thorough consideration of possible apparent retardation as a result of emotional maladjustment. Every such placement also needs careful follow up. In the case of the child who is found to be of average or above average ability, the present school placement must also be considered as to suitability for the particular child.

It has been my experience that children referred because of specific subject disability are often superior in general ability, but have developed a specific block or accumulation of difficulty in the particular subject or subjects. They have experienced failure, criticism, humiliating or frightening situations which have led up to the present recognized difficulty.

In planning a specific remedial program, it is well at first to disregard the present grade requirements. The program must start at the most elementary level of difficulty revealed by diag-

nostic tests in the specific subject. Only by such a plan can we hope to build the necessary foundation in the subject and the related sense of security. It is of course very helpful to obtain the cooperation of the school so that grade requirements can be temporarily suspended. Should this not be possible, the therapist must nevertheless disregard them. In this respect a truly therapeutic remedial program differs from a coaching program which is concerned primarily with current school assignments rather than basic needs.

The program formulated should include a tentative long range plan and a more detailed one for the immediate week and day. Any plan will need to be tentative and flexible so that it can be adjusted as the work progresses. A detailed working plan is extremely important. Without carefully considered immediate and remote goals the program is in danger of becoming haphazard and ineffective. One must be aware at every step as to why a specific game, exercise or therapeutic procedure is being used. We must constantly question our share in the procedures in order to ensure that each step is pertinent to our combined subject and mental health goals. In remedial teaching, as in all therapy the child should be the active member and the therapist the friendly guide. Real progress and insight take place only when the child is actively participating. Here, as in all therapeutic programs we must proceed slowly enough to relieve accumulated tension and thus make growth possible. As one child of ten, put it: "You're so comfortable to work with, you never get cross." This spontaneous comment was followed for some time by efforts to try me out and reassure herself that she could really feel free to be herself.

During the early days of the program every effort must be made to ensure that the previously distasteful subject becomes interesting. There is often accumulated severe dislike to overcome. This can be best achieved by being careful to start where success can readily be attained and given recognition. With young children the game element helps at this introductory stage. Care must be exercised, however, to ensure that the game element is not the main feature. It must be mainly related to the needs of the particular child at that time. Selection of suitable material is an important factor. The child's general interest must be taken into consideration, especially in reading. Time spent in exploring the child's interests and hobbies is often very rewarding. Armed with

such information, the therapist can select or prepare material which will arouse interest and still meet the child's immediate needs.

There is much good work book material available. This material should, however, be used according to each child's needs and must often be supplemented by specific exercises prepared to meet identified individual difficulties. Frequent repetition in varied interesting form is essential all along the way in order that the child may develop competence at each step. The experience of knowing what he has to do and of being able to do it, will bring with it the desired self-confidence, self-esteem and feeling of security.

Teachers and parents often report improvement noted in attitudes and in regular class work even in subjects unrelated to the remedial program. This occurs even when the work of the grade is entirely disregarded. The improvement noted seems to be related to the general therapeutic value of the program. The child's increased self-confidence and self-respect carries over to other areas and the presenting symptoms tend to disappear when the basic personality adjustment is improved. Gradually, teachers and parents are likely to report that certain disturbing traits or behavior manifestations are no longer evident. As one mother of an eight year old remarked: "By the way, Mary doesn't vomit any more." The vomiting, occurring mainly before leaving for school, was the major reason for referral by a pediatrician who found no physical basis for it. It proved to be merely one symptom of the general tension and frustration.

To sum up, children who are experiencing difficulty in school and who are not physically ill or mentally retarded are often in need of a therapeutically oriented remedial program. This program should combine good diagnostic and remedial techniques with a psychotherapeutic approach.

It is not possible here to describe such a program in detail. An effort will be made however, to discuss certain salient steps which would follow the initial tentative diagnosis and plan.

(1) It is important to analyze the accumulated background information from all sources and the diagnostic findings with a view toward understanding the child's present emotional and educational status and forming a tentative picture of related developmental and environmental factors. Thus we will gain a picture of the child and his problems.

(2) An effort should be made to initiate such environmental

changes as are indicated and possible. Conferences with parents and teachers often help to eliminate or at least neutralize present factors aggravating the situation. Needless to say such conferences must be undertaken as an opportunity for the parent or teacher to gain insight gradually. Any attitude of direct advice is usually unproductive.

(3) Early contacts with the child should be mainly concerned with establishing a good relationship. The child's first need is to find that this is a situation quite different from any he has ever experienced. Here he experiences no criticism or pressure. On the contrary he sees that his needs are seriously considered and that here is someone whose only purpose is to help him in any way he himself feels the need to be helped. In other words, here is a situation where he can feel free to be himself and express his needs, fears and anxieties without any repercussions. He can feel sure of finding friendly but unobtrusive acceptance.

(4) A tentative starting point must be established, at which the child can succeed and obtain recognition of this success. In determining this starting point nothing must be taken for granted. The optimum level must be determined on the basis of individual diagnosis. In arithmetic, for example, it is necessary to determine whether the child has an adequate concept of number and of the fundamental operations, before going on to number combinations. This is true no matter in what grade the child may be.

This diagnosis cannot be made by merely inspecting the results of written tests. It is not enough to know that a child has failed on certain examples. We must find out, by having the child work these examples aloud, just why he failed in each case. Having previously gained the child's confidence, we must give him an opportunity to find that we do not criticize or scold and are interested only in finding out with him just where he needs help. In this comfortable atmosphere the child will soon feel free to work in the teacher's presence and to participate without anxiety in locating his difficulties. The same is true of remedial reading or any other remedial program.

(5) Whether we are building basic concepts of number or basic reading vocabulary, it is important to proceed slowly enough for the child to gain recognized competence at each step. This means we will apply each new group of number facts or words in varied games, exercises, stories and activities until they become thor-

oughly familiar and meaningful. Frequent repetition in varied form is essential to establish this firm foundation and its related growth in confidence and self-reliance. This repetition must be free of any emotional reaction on the part of the therapist who must remain accepting and non-critical. Praise is often as damaging to the child's growing security as is blame. The child's reaction to praise is likely to be fear of not being able to continue at the same level of success. The therapist must remain the patient collaborator. One child remarked spontaneously: "Don't you get mad when I get it wrong?"

Should diagnostic tests reveal that the basic difficulty is in some more advanced area of the subject, it will of course not be necessary to go back to the most elementary material. In each case, we must find out what the child already knows and understands as well as what he has not yet succeeded in learning. Thus each program is individual in so far as starting point, areas of practise and rate of progress are concerned.

It may be necessary to relieve anxiety by spending some time here and there on immediate difficulties which the child encounters in his daily work at school. Too much of this "patch work" will however interfere with the long range goals of the therapeutic program.

It is important that all persons concerned, parents, teachers, therapist and the child himself, realize that the difficulties were developing over a period of time and that they cannot be expected to clear up quickly. Often the most important and rewarding part of the program comes after the subject disability has been pretty well conquered. We must not lose sight of the fact that our aim is primarily to effect an emotional readjustment of the child as a person and incidentally as a school pupil.

AUTOBIOGRAPHY (VII)*

WILHELM STEKEL, M.D.

WAR'S END

The last winter of the war was the most severe I ever experienced. The food was poor in quality; there were so many substitutes, that we all were more or less undernourished. My room at the hospital was barely warm, while the wards were very cold. We did not have enough fuel and the large rooms, wooden walls and large windows, would not get comfortably warm even with constant heating. The temperature in the rooms was a few degrees below freezing; the patients had to lie in bed fully clothed, and covered by blankets, but they were happy not to be in the trenches. There followed horrible weeks in which an epidemic disease called Spanish influenza mowed down the strongest, like grass before the scythe. The doctors, too, were infected, and we, the heads of the departments, at other times free from night duties, remained alternately overnight in the hospital. One night, when I was on duty, twenty soldiers from Bosnia, most of them strong, athletic men, died, whereas many weaklings made a successful fight for life.

A short time prior to the end of the war I was ordered to go to Bosnia.¹ There was a shortage of physicians there and I was to be assigned to duty at an isolation hospital at Sarajevo. I was desperate. To leave my familiar hospital, the hospital I needed for the writing of my new book, and to go so far away from the woman I loved. I went to the physician in charge of the medical service in the Army; he was very kind. He knew it was absurd to send me to Bosnia, since he had no substitute for my services in Vienna, and it was stupid to transfer me to an isolation hospital where the work was new to me.

"What kind of cases are taken there?" I asked.

"It's a hospital for spotted fever."

* Cf. AMERICAN JOURNAL OF PSYCHOTHERAPY, April, July and October 1947, January, April and July 1948 issues.—We are publishing a series of excerpts from the manuscript of the famous pioneer of psychotherapy. Stekel's memoirs throw a light not only upon the personal background of an interesting man and a great physician, but also upon an early era of psychoanalysis in which the author played a prominent part.—*The Editor*.

¹ Now a province of Yugoslavia.—*The Editor*.

"But I have hardly any experience with such epidemics. I am not afraid of infection, but—I am a psychiatrist."

"It doesn't matter. You are a soldier and have to go where you are sent. However, if you can get me a substitute, a doctor who is willing to go to Bosnia, you can remain here."

We were receiving twenty *kronen* a day at our hospital, whereas a doctor at an isolation hospital would receive thirty *kronen*. But what did money mean to me at that point! I had just published my third volume of the *Disorders of Instinct and Emotion, Frigidity in Women*, and the fourth volume, *Impotence of the Male*, was almost ready. I had to get out of the assignment. Worried, I left the office. Just outside the gate a colleague addressed me, a man who had heard one of my lectures. He was a war refugee, living in Vienna, with his wife and two children, and completely destitute. He was eagerly looking for a job. "I can offer you one", I said joyfully. "How would you like to earn thirty *kronen* and board a day." "It can't be possible," he cried, "you are my savior!" I brought him in as the substitute. . . . Shortly afterwards the war came to an end.

BACK TO CIVILIAN LIFE

Armistice Day—what joy! In the same mood I have greeted the first blossoming tree after a severe winter. The sufferings of the population were beyond endurance. The bones of many of the people had become soft from defects in the diet; the streets seemed filled with cripples. I was fortunate enough to go through the war without this sort of illness.

The first weeks after the armistice were electrifying. Revolution was in full swing; there was street-fighting, and it was dangerous to be out after dark. These risks did not deter me from going to see my dear Gulf every night. We discussed our divorce difficulties. My former wife asked such an enormous alimony, that I could not see any way out. Through devaluation I had lost all my savings during the war. The war bonds were worthless. The problem was how to obtain the capital for the divorce, and for the establishment of a new home.

At this juncture, one of my English patients, Harold Coxeter, now dead, made me an offer so kind, that I shall never cease to be grateful. Having heard that my divorce was blocked by my wife's demands for alimony, and having a great admiration for the lady

who was to become my second wife, Coxeter offered to advance the necessary sum if I could pledge myself to pay the interest on a loan he would effect at the bank.

I was strongly tempted to accept this generous proposal, but Gulf would not hear of my assuming such an obligation. She persuaded me to refuse,—with heartfelt thanks. (Following Coxeter's untimely death, his widow and her mother, Mrs. Gabler, have been two of my best friends.)

At this point let me consider the question, who was responsible for the unhappiness of my first marriage,—my wife or myself. Far be it from me to repudiate my share of responsibility. I have, indeed, stressed the merits of my first wife. She was a woman of fine qualities, and it was natural that I was attracted to her. But the best man and the best woman in the world may fail to amalgamate properly in married life. ("You marry a woman you love," a famous English novelist remarked, "to find next morning that you have married a stranger.") In our case, my wife and I, after our marriage, developed in different directions, whereas Hilda and I have drawn closer together, finding more and more in common, working in the same field, having and developing common interests, and a common outlook upon the world. In my book, *Marriage at the Crossroads*² I expound the prerequisites for a happy marriage. Here I should like to emphasize once more that mine was indubitably a difficult temperament to get along with, that my vital rhythm was much too different from that of my wife's, and that it was my *elan vital* that often led to our misunderstandings and clashes.

AMERICA IS BECKONING

Gradually a circle of pupils formed in Vienna and many adherents and friends came from abroad. Among them was Tannenbaum, an American, who came to visit me after the war.³ During the war he had sent me many parcels of food. He came to Vienna to see me, believing that he would fulfill a great mission if he would reconcile Freud, Adler and Stekel. But he was not very successful in this matter, although I for one was willing enough to accept

² English translation by Allen G. Garman, William Godwin, Inc., New York, 1931.

³ Samuel Tannenbaum, M.D., of New York. A notice about his death in October 1948 appears in the column "Notes and Comments" of this issue.—*The Editor.*

reconciliation. He invited Adler and myself to a box at the Opera. We accepted—but there matters remained.

Tannenbaum frequently advised me to study English. In the United States, he said, I could establish a new future. But he returned home before I had time to learn English.

Some months later I received a cable from my friend Tannenbaum asking me to come to America. The cable ended with the words: "I am sending money."

I had never accepted invitations to go abroad. I was always too busy, and my work on *Disorders of Instinct and Emotion* was too important to me. I was different from Adler, who went all over the world and was the most successful propagandist for his theories. But now I had to accept this offer. I needed money for my divorce. I had only a short time left in which to study English. In youth Gulf had studied this language for a short time, but she did not know enough to become my teacher.

So we went to a well-known English teacher. This woman thought I should learn grammar from the beginning. I have never picked up a language by studying its grammar. I learned foreign languages by reading and by conversation. I asked her to converse with me. "You will never speak English," she said to me in an irritated voice. But I decided to pursue my customary plan. I began by translating Shakespeare's *Julius Caesar* and I spoke, as best I could, English with my future wife. She corrected my pronunciation with inexhaustible patience. The pronunciation of English, how difficult! To a foreigner English spelling is a "teaser"; one has to memorize the spelling of every new word. Nevertheless, I made a little progress; I was able to use a few words. Again chance helped me unexpectedly: I got a new teacher. This teacher was an American physician. He wanted to study psychotherapy; his means were modest, and I proposed that we should exchange services. "I'll give you the psychiatric lectures in English, and you will correct my mistakes." I realize now that he had the worst accent I ever came across, but for me it was the purest English—I knew no better. I gave him my lectures, which he seldom corrected; instead, he repeated again and again, "You are doing very well." He was married, and one day he showed me a letter from his wife, in which she mentioned having made the acquaintance of a very nice neighbor. At the end of the letter was the sentence, "He is as lonely as I am." The "n" of the "lonely" was

written over a scratched "v". I gave him a discourse on "slips of the pen" and explained how Freud had found out that there was always an underlying motive for such errors. He became very upset and shouted, "I'll find out all about it. If this is true with her I'll get rid of her and that rich fellow will have to pay me twenty thousand dollars." He hired a detective and procured evidence of his wife's infidelity. Then he returned home, secured a divorce, and collected twenty thousand dollars damages for the alienation of his wife's affections. Later I regretted having used his letter as an illustration for a lecture on "freudian errors."

Soon I received a check from Tannenbaum for a thousand dollars. I booked passage on an English boat, and shortly thereafter was on my way.

I arrived in Antwerp, my port of departure, two days before the boat sailed. It was shortly after the war, and I was one of the first Austrians who were permitted to travel to America. The first hospital I served in during the war was a Red Cross hospital, and I was twice decorated by the Red Cross. I carried a recommendation from the Red Cross office, which enabled me to travel as a member of this International organization. In Antwerp I found so much animosity towards Germans and Austrians that I took care to speak only English. I spent some enjoyable hours in Brussels, walking in the old national square and visiting the Royal Museum of fine Arts.

My ship touched at Southampton. Waiting there to see me was my good friend and former pupil, Rosalie Gabler, who had made the English translation of my book, *Anxiety States*. When the war ended she had sent me many parcels of food, and now she feared I might not have enough food on the boat. There she was with a basket of chocolates, apples and other delicacies. During our enjoyable conversation, she seized the opportunity to ask me for a definition of the unconscious. It was a dark night and a searchlight was playing round the harbor. "Look around" I said, "You can see only what the searchlight illuminates. There are many other objects in the harbor, but you see only those on which the light falls. Our consciousness is like the harbor. We are able to see things only when our attention is directed to them. Other thoughts are not unconscious and while not perceptible, they are always able to come back into consciousness."

Rosalie Gabler is now a well-known psychotherapist; she never

visits me in London without bringing some gift. Some people are "takers." She is a "giver."

For a long time I had been longing for an ocean voyage. I lay in a deck-chair, studying my English and enjoying the rhythmic action of the boat. There were a lot of Americans aboard and I found it difficult to understand them. Sometimes as I listened to them it was as though I heard a foreign language; I exchanged some words with the Captain, found that I could understand his English and that he understood what I said. This gave me a little comfort.

The food on the English boat was very rich, but not at all to my liking. All the dishes tasted alike, and I understood then why English people use so many different spices and sauces which are less known on the continent.

NEW YORK

In New York my friend Tannenbaum met me at the pier, and after the necessary formalities at the customs, brought me to his apartment. Tannenbaum was surprised that I was able, more or less fluently, to converse with him in English. I told him that I wanted to see New York at night, especially Broadway. This was not possible, however, since he had arranged for me to speak at the Women's University Club. Evening dress was required, so I had to await the arrival of my trunk. (It was the only time I wore evening clothes in America.) At last we were able to go to the club. I had expected a reception by a committee. Instead, I entered a small room, where I was introduced to four elderly women wearing large spectacles. After the usual formalities, these women began a barrage of questions about starvation in Vienna, about the unconscious, about transference, and so on. By this time I was bored and tired. I understood that Tannenbaum had promised these ladies to bring a "well-known analyst" (my name was already known in America) to his acquaintances, and they grasped the opportunity to squeeze me like a lemon.

For some time I had been suffering from urinary trouble due to a hypertrophy of the prostatic gland. I had to empty my bladder soon after the desire manifested itself. I noticed that in the streets of New York there was a lack of public comfort stations. A friend of Tannenbaum advised me that in such emergencies I should go to the nearest hotel, adding, "This is a country where

you have to be the master of your bladder.” The next day he became my guide to the curiosities of New York. He availed himself of the opportunity to speak about the conflict he had with his father and to ask my help. (Later in Chicago I met his father and was able to reconcile father and son.) The father was at loggerheads with the son because the son had married without his permission. (At the time of the marriage the disobedient son was forty years old!)

What did I want to see first? You can perhaps guess. It was the Metropolitan Museum of Art. I was astonished to find in one room over twenty Rembrandts. I enjoyed the outstanding collection of famous French painters. I was so engrossed that I forgot all about my bladder trouble; but my guide, Mr. S., wanted to use a comfort station. It was then just twelve o'clock, and the attendant would not permit him to use the men's room. The gallery was closed from twelve to two. While the poor man wriggled in pain, we hired a taxi and went to Central Park where such a station was available. The attendant told him that this so necessary commodity would not be opened till the first of May. Again a taxi, and with many admonitions to the driver to hurry, we arrived at the releasing place in a subway. This was my first experience of its kind. Mr. S., had identified himself with me, always waiting for me to ask for a comfort station, and through auto-suggestion and fear, he unconsciously played my part.

Tannenbaum urged me to go to Chicago as soon as possible. I had to see a difficult case there and, in addition, he had other cases in New York which he could not finish. At the same time I had various lecture engagements. On the third day after my arrival I left on the “Century” for my destination. I had an upper berth and was astonished that a pretty young lady was the occupant of the lower. Was this a mistake? But the colored porter told me that that was alright. I and the young lady looked out of the window as the train sped along. Finally, tired of gazing, I tried to read my English book and to use the dictionary. The lady also read, looked at the scenery and yawned occasionally. I had been cautioned against addressing strange women in America, since it was not customary; nevertheless, I engaged the lady in conversation. She appeared pleased, and inquired as to my profession and destination. I told her that I was a foreigner, a psychiatrist, on the way to lecture in Chicago. She in turn told me that she

was newly married and was on her way to Chicago to act as a bridesmaid at a friend's wedding. I received the impression that she was not too happy in her marriage. Then she talked about her father who suffered from a nervous condition, and asked if I would be willing to see him in New York before returning to Vienna. Then we both retired. (I found it was most uncomfortable to undress behind the curtains of the berth.)

• Later I received several letters from the lady, reminding me that I had promised to see her father upon my return to New York.

This was during prohibition; liquor was taboo; soliciting by prostitutes was against the law. Everything was sham morality. In reality life was different. It is impossible to repress instincts by laws; ways or means will always be found for their gratification. The unenforced prohibition law became a danger, even for girls of good families.

CHICAGO

In Chicago I was met at the station by my patient, who soon became my friend. He was a member of a highly intellectual literary group, many of whose members later became my patients.

It was a distinct relief that my friend assumed all financial arrangements. I did not ask for money, or handle money. Through consultations I had earned in a few days more than I did in an entire month in Vienna. I worked from early morning until late at night. At the end of two weeks I delivered my first lecture before the Neurological Society. The hall was crowded. The doctors present had heard that the lecturer could barely speak English. They were prepared for a good laugh. But I had learned to juggle my limited vocabulary so skillfully, that I came through the ordeal with flying colors. I spoke on "Impotence in the Male." Among other points I explained that for men of a certain age their secretaries and stenographers constitute an emotional danger. I said, "If a married man over forty comes into your consultation room and complains of impotence, watch for his stenographer." A roar of laughter followed; unwittingly I had touched a vulnerable spot. I later learned that at that time a famous professor had been dismissed from a university because of an affair with his stenographer.

The lecture made me popular, and I received so many invitations from my colleagues for lunch or dinner that I was unable to

accept them all. These invitations became a nuisance. My friends urged me to accept, as it was important to make contacts. I had no time to dress formally, and so all invitations were accepted with the stipulation that there would be no formalities. But alas, as during my first evening in New York, there was always a contingent of elderly ladies, wearing horn-rimmed glasses, in urgent search of information. I therefore added a second condition to the acceptance of invitations, and that was, that I was to be spared the ordeal of endless questions.

Luncheon was usually at some Viennese restaurant, to which I was taken by car, and where the entire group ate. My friends usually rolled dice to determine who was to pay the bill—I was never permitted to pay. These luncheon parties were time-consuming, and I did not have any time to spare. I preferred to eat in my hotel.

My position was a very delicate one. We had been taught by Freud that a psychoanalyst should not be in private contact with his patients. I was with my group all the time. On Sundays we made excursions. I had to be very careful not to show any preference, not to talk longer to one than to the other. Everyone wanted to draw me into a corner for some private communication. I had to bear in mind the factor of human jealousy.

Among my acquaintances there was a pretty girl. One day, while taking a walk, I noticed her leaning from her window, waving and beckoning me to wait. She came down and taking my arm, commenced to talk about her life. She was twenty-six years old and had had no affairs with men. She was not like other modern girls who have various experiences before marriage; she would give herself only to a man she could esteem. She went on to say that one of my patients, Judge D., had evinced great interest in her, but had never proposed marriage. I expressed the hope that I should be able to induce Judge D. to become engaged to her. D. was a man of thirty, who had paid attentions to several girls, with the intention of marriage, but he always backed out before committing himself. He was a typical doubter and wanted to be cured, as it was high time for him to found a family. He had a strong mother fixation. His mother could not go to sleep without a good-night kiss from her son. He took a room in my hotel. Sometimes we were at work together until late, sometimes the weather was bad, but nevertheless, D. had to run to his mother's hotel to give her the usual good-night kiss.

Once he brought me the following dream:

I am in a room with many lamps. There are several switches. I try to switch on a light, try one lamp after another, but they do not work. I call the electrician and he informs me that there is a tungsten bulb among the other lamps. He removes the tungsten lamp, telling me that now everything will be alright. He leaves my room with Queen Victoria, whom I had not noticed before. I then try the various switches and am glad to find that they are all in order.

I gave him the interpretation of the dream. I am the electrician, and the tungsten lamp is the symbol of his mother. His attachment to his mother hampers him from marrying. Queen Victoria is his mother too. This is what we call a doublet (repetition of symbol), stressing the importance of the mother complex. He marvelled at this simple interpretation. Three days later the girl came to my room, handed me a big bunch of roses, embraced me and kissed me. She said, "I am engaged to Judge D., and I am so happy! I know that this is your work and I shall always be grateful for what you have done."

I should mention that the literary group held weekly meetings. There were discussions of prominent books and I always had the last word. Every one present listened to my words as to the words of a prophet. This blind adulation was sometimes overwhelming; I had to be careful not to let it go to my head. Sex topics were discussed without restraint. I received the impression that many women were taking advantage of psychoanalysis to lessen their usual social restraint.

I was, of course, not the only psychoanalyst in Chicago. Analysis was very popular in this city. Even laymen and quacks turned to the new science in the hope of earning a good income; a one-time barber lectured to large audiences. Advertisements appeared in the newspapers, "Do you want to be successful? Do you want to be energetic? Do you want to be rich?—Come to my office to be analyzed."

The last lecture I delivered at the University of Chicago dealt with "Psychoanalysis, its Limitations and its Abuses," repeating once more that analysis was not a usual branch of general medicine. I emphasized that it was absurd to maintain that any and every illness could be cured by analysis, or that healthy and well-adjusted persons should be analyzed. I maintained that only

those who have lost the joy of life, feel insecure, or are hampered in their social functions, should be submitted to analysis.

In the meantime I had made considerable progress in English. I delivered my lecture, as I did all my lectures, extemporaneously.

TRUTH IN ANALYSIS

One experience recurred several times in Chicago. Several people tried to fool me by telling me deliberate lies. One girl boasted to her friends that she had fobbed me off with invented stories, which I had believed. I had realized all the time that her stories were inventions, but pretended (at first) to believe her. It is my principle to listen to my patients, to behave as though I believed them, and to await a critical moment when I tell them they should stop lying, and should stick to the truth.

Once a lawyer came to see me and asked me to examine a man who had been arrested as a homosexual offender and had just spent a week in jail. He had been caught with another man in a men's room. The lawyer begged me not to mention that the patient had been jailed; he had promised his client not to talk about it. The patient came, and I did not mention the fact about the jail, hoping that he himself would confess it. Analysis is impossible if the patients wants to keep something back. He is unable to produce free associations, being inhibited by what he hides, and nothing else comes into his mind. My patient had recourse to various tricks in order to waste time. At first he spoke so softly that I could hardly hear him. Then he half-swallowed his words. I asked him to speak more distinctly, which he then did, with manifest reluctance. Finally he admitted his paraphilia. Once in a while he would be overwhelmed by an irresistible impulse and compelled to go into a comfort station and pick up a man who would join him in homosexual practices. I explained to him pointedly that it was high time for him to be cured, as otherwise he might come into conflict with the law. "Oh," he said, "It couldn't happen to me; I am very cautious." Two weeks went by and still he did not confess. I told him I would no longer treat him. He was not frank, I said, and therefore any further analysis was useless. He protested that he would take an oath that he was not keeping anything back, but I did not change my decision. One day prior to my departure from Chicago he came to my room to apologize. He was willing to confess everything, and was at a loss to understand

why he had lied; he regretted his insincerity, and said that he would never forgive himself for having muffed his chance of being cured.

SUCCESS

I could not accept all patients who came to see me for consultation. Had I remained in America I would have become wealthy, and what is much more important, I would not have become a refugee from Austria. But my longing for my loved one was a magnet that was stronger than money. Besides, life in America in general did not appeal to me.

My greatest successes were unhappy marriages. While in the U. S. A., I adjusted a number of unhappy marriages. In many cases I was able to rectify the environment, to smooth the discords, and to teach men and women how to behave. Sometimes by finding out what was wrong and advising the right course I was able to readjust matters in one session.

Some mothers asked my advice in matters of bringing up their children. I had the opportunity to examine a nice little girl, aged three-and-a-half, who suffered from a habit of prolonged chewing. She used to keep the food in her mouth, masticating it for half-an-hour or more, and would finally spit it out. The whole day was spent in attempts to force the child to swallow. The child looked pale and emaciated. I was also told that she struggled against her bath, and yelled when put into the tub. I asked about her home environment and was told that there was a little brother. "Does she cry when her brother is bathed?" "No. She is always present and likes to look on."

The atmosphere in the home was very bad. The child often witnessed quarrels between her parents. I concluded that she was jealous of her brother and hoped that he would be drowned in the tub; hence her fear of being drowned herself, the well-known law of retribution. I advised the child's parents never to quarrel in the child's presence and not to permit her to be present when her brother was given his bath. Finally, the most important advice: "Don't pay any attention to the child's habit of 'chewing the cud.' She wants to distract you from her little brother. Behave as if you did not notice what she is doing."

Next day when the child started to "chew the cud" again her mother paid no heed. The little girl was astonished. A second

time she repeated the chewing without drawing any notice. Two hours later she came to her mother and asked for food, saying, "I am so hungry." She was cured. Three weeks later I met her in the park and scarcely recognized the rosy, plump little girl, full of the joy of life—an absolutely normal child.

You can understand that the story of such successes was easily spread. Some people came to ask advice in special difficulties.

While in America I had the definite impression that American husbands often disregarded the art of love. Business seems to be their main outlet and they treat their married life like a part of their business.

Warned by my colleagues, I avoided any publicity in the newspapers and declined to give interviews. Four days before my departure I yielded to a prominent journalist and granted him an interview. Referring to the money complex, I explained that I find the younger generation in a rebellion against the money complex of their elders. The interest in art and science was growing among the young. I was convinced America would continue successfully the mission of the Old World. In the course of our conversation, ranging from the modern make-up of women to the law prohibiting prostitution, I casually remarked that some women were now so elaborately made up and so provocatively dressed that it had become difficult to distinguish between the "decent" and the "indecent" ones. This part of the interview became a sensation of the day. It had a disagreeable effect. The telephone rang all day, and I was besieged by reporters with requests for interviews. People whose acquaintance I had made crossing the Atlantic and who I thought had forgotten me, sent me urgent invitations, all of which I had to refuse.

In my hotel I was not known as an analyst, but as a pianist. (I found that in many American homes you will find a piano, but the players—as a rule—are not very far advanced.) There was an excellent Steinway piano in the hall of my hotel. I used my free time to improvise. Little by little I collected a devoted audience, guests from the hotel, the elevator boy, the girl who sorted the mail, and a strikingly beautiful maid who always came down to do the cleaning when I played. The most enthusiastic listener was a colored bell-boy.

Before I left a dinner was given in my honor. One woman eulogized me because I had adjusted several marriages. I realized

that before my arrival many people believed psychoanalysis and divorce were synonymous, and that analysts, as a rule, advise their patients to get divorced. I considered it my foremost duty to improve marriage relations and to preserve marriages, especially when there were children. (The children of divorced parents form a depressing chapter in our times.) Then one of my friends and patients whom I had relieved from a cat phobia delivered a speech full of exaggerated praise. He went so far as to say that Europe had sent a god as a messenger to save people who suffer. His flat-tery annoyed me somewhat, and so I made a humorous speech. I said: "The devil in Europe was bored with his monotonous work, and decided to go to a new country, where his mission was as yet unknown. He played the role of a god so perfectly that everyone believed he really was one."

WASHINGTON, D. C.

Before leaving the United States, I was invited to Washington, D. C. by the prominent psychiatrist, William A. White, superintendent of St. Elizabeth's Hospital. I begged him to invite Tannenbaum as well, which he did. Tannenbaum asked me about my results in Chicago, since some of my patients were his former patients, he wanted to know details about their personal lives. I also perceived at that time that he was jealous and foresaw that our friendship would come to an end.

In Washington I delivered a lecture. My audience consisted of the staff of St. Elizabeth's hospital and other guests. Tannenbaum was the chairman.

That night I hoped for an opportunity to talk with White, but Tannenbaum produced a volume of Shakespeare and began to read the sonnets. I could not understand them at the first hearing. I excused myself, went to bed, but poor Dr. White, the host, had to listen to the entire series. Next evening Dr. White gave a dinner in my honor. I was seated next to Roosevelt's sister.

MY FRIEND, THE GANGSTER

I should like to interpolate here the case history of Mr. B. of Chicago, a Jewish boxer, who later became the owner of a jewelry store. At the time he was faced with a very important decision. In his shop he had a pretty little woman as an assistant. Her former marriage was unhappy. Her husband was a gambler and

a drunkard, who beat her and humiliated her on every possible occasion. Mr. B. helped her to obtain a divorce, and being enamored of her, he proposed marrying her. The girl told him frankly that she was very grateful for his help, that she esteemed him highly, but that she was not in love with him. However, she added that she was ready to marry him if it would make him happy. He asked me what he should do. I warned him against entering into a marriage with a woman who did not love him.

I was back in Vienna, had already forgotten Mr. B., when one day I received a phone call from Berlin. It was Mr. B., asking me if I could take his wife for treatment. A short time later she arrived, a charming little lady. She told me the following story: B. was entangled in a disagreeable affair. He was a member of the Chicago underworld and had been put in prison because the police suspected him of being implicated in the matter of some stolen bonds. He was in prison for three month, pending trial. The authorities could get nothing out of him; he would not betray his accomplices who had stolen the bonds, so he was released. One day he was invited by his accomplices to take an automobile trip. Suspecting foul play, he jumped out quickly, and there was mutual shooting; but the police came and he was saved. Now he was forced to go into hiding. During the time he was in prison he had sent his wife to Paris. There she met a young American and fell in love with him. Mr. B. came later to Berlin, sent for his wife, and found her a changed woman. She refused marital relations, being still dominated by the image of the young American. In the end she insisted she could not go on with her marriage. (Esteem is a weak substitute for love.) Mr. B., came to Vienna and asked me whether in my opinion his wife would ever love him in the future. His hope was that he could win her over by kindness and devotion. I reminded him that in Chicago I had advised him against the marriage.

"Does your study of my wife indicate that she still thinks of a divorce?"

"That may be her wish. Gratitude obliges her to stay with you."

"I don't care for her gratitude. She will get her divorce."

He kept his word, divorced her, gave her a share of his money, and she left for America, where she became a chorus girl.

B. came to me for treatment every day. He suffered from a

colitis, but one day he noticed blood in his stool. I sent him to a specialist, who found an ulcer in his rectum. He had to be operated on. Before the operation he entrusted me with his money and jewelry and made me the executor of his will. He begged me to hold his hand during anesthesia and to be present at the operation. The operation was fairly successful; but later he had to undergo a second and a third operation. By this time his funds were exhausted, but he had only to write to his confederates in Chicago and threaten to "talk" and they would send him money to go on. In spite of his conduct, I felt sorry for this man. He had some good qualities, and he became deeply attached to me. In summer he hired a room near my country house and would pass it just to see me working in the garden and to greet me. Many times I also met him near my office in the city. He was always happy to see me, to shake my hand. At his third operation, I had, as usual, to hold his hand. He was given ether. During the period of confusion following the anesthesia, he said that he loved me passionately, that he grudged me to any human being. When he walked outside the place where I was working or resting, he toyed with the idea of killing me to make sure that I would not be possessed by any other person. He died shortly after the third operation, following an accident. Even love is a danger. Every analyst is exposed to the risk of being attacked by a jealous patient. I have often thought of the words of Oscar Wilde, "and each man kills the thing he loves."

STEPPING ON OTHER PEOPLE'S TOES

Little differences of opinion have sometimes great importance. Tannenbaum was an ardent lover of Shakespeare. He had an excellent Shakespearean library. On my last day in New York I mentioned that I shared the belief of many that Bacon actually wrote certain of Shakespeare's plays. He was furious as though I had committed a crime. (As if it matters who was the genius who wrote those wonderful plays.) I had touched a tender spot and he never forgave me.

On the boat coming home, a man saw my name on the passenger list and wrote me a letter. "Are you the well-known Stekel who wrote an excellent book on dreams? I would like to get in touch with you." We became acquainted. He was the manager of one of the large banks in New York, and was on his way to an international conference of bankers in Europe.

We had many interesting conversations and he introduced me to his young wife. He confided to me that he had married her because she was a fanatical atheist. Atheism was the main topic of their conversation. Such fervid atheism is usually a screen for repressed religion. The truly convinced atheist does not emphasize his atheism. He does not talk about it and is careful to avoid blasphemies.

The man was interested in dreams and each morning he related several of his dreams. They were full of religious symbols. I was cautious not to reveal to him the meaning of his dreams; such off-hand analyses are always dangerous. A patient must be ripe for recognition; he must go through a period of preparation (transference). It is interesting how this man one day turned away from me. I had published a short pamphlet on telepathic dreams. During the war I had gathered many experiences as a confirmation of the existence of telepathy. I was never inclined to believe in mysticism and was sceptical as far as metapsychological matters were concerned; but facts are facts. It would be unscientific to shut our eyes to the truth, however unwelcome it may appear. What is so miraculous about telepathic dreams? We know since the discovery of the radio that electric waves can be transmitted over vast distances. Can we not suppose that the brain sends out some sort of waves and that another sensitive brain may be able to receive them? I myself have had some telepathic dreams. I consider the existence of telepathy as proven. I lent the banker my pamphlet, but I did not anticipate the results. He wrote me a short letter saying that he could not continue a friendly relationship with a man who believed in telepathic dreams. He had lost all his former respect for me.

Again I had touched a tender spot. Telepathy is akin to a miracle, and miracles are a part of religious belief. The banker did not want to be disturbed in his supposed atheism, and belief in telepathy reminded him too much of his former religion. His atheism was a reaction formation established upon an ineradicable religious belief.

EUROPE

For many years I had been obsessed with a longing to see Paris and to visit the Louvre; but upon my arrival in Europe my only thought was "When can I see my Gulf?" After exchanging many

telegrams and after three endless days of waiting I met her in Salzburg and we went together to Gastein, where I made my preparations for divorce.

Meanwhile, I had published new books; before my trip to America, *Impotence in the Male*⁴, and shortly after my return the fifth volume of my *Disorders*, entitled *Psychosexual Infantilism*. In Vienna I bought a little old cottage with a nice garden, the new habitation I was to share with my beloved. At this time the dollar had gone up, the *krone* went down, and everybody gave me the advice to change my dollars at the then excellent rate of exchange. I was foolish enough to follow this advice and I lost what was left of my dollars.

New pupils from Vienna and abroad joined my group. I set up an office in the heart of Vienna, and we moved into our new home. How happy I was! I had a peaceful home, a little garden I could work in, and I progressed to the sixth and seventh volume of my *Disorders*. My children were now married, and my former wife was provided for. I had my own school, was very busy and had sufficient income for all my expenses. What more could I wish for? As a youth I never craved for wealth. But I had two secret wishes. I longed for a garden with many roses and, in summer, I wanted to have as much raspberry juice as ever I wished. These two wishes were fulfilled. I planted lots of roses in my garden, and in summer plenty of raspberry juice was kept ready for me until this harmless pleasure was cut off by diabetes.

At that time my pupils in Vienna, in addition to Gutheil, were Anton Missriegler, Ernst Bien, Ernst Rosenbaum and Fritz Wengraf. I had so many patients from all over the world that I kept not only busy myself, but was able to help my pupils by referring cases to them.

How did I procure patients? Usually they were sent to me by their physicians, but I also had a great number of physicians themselves. Some patients came in a curious roundabout way.

One day a patient from Bulgaria, who suffered from a complicated form of fetishism, learned about me in a peculiar way. He was the head of a paper mill, where old newspapers, books and other rubbish were pulped down to make newsprint. Amongst this rubbish he saw a large green volume—my book with the title,

⁴ English translation by Oswald H. Boltz, Liveright Publ. Corp., New York, 1927.